

13636

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 27 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. STREET ADDRESS 11 Madison Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last John Michael Barnes				4. DATE OF DEATH Month Day Year Dec. 12 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 17, 1894		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 7 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Koppers Co.		11. BIRTHPLACE (State or foreign country) Adelaide, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Barnes				14. MOTHER'S MAIDEN NAME Dorothy Markus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-3817		17. INFORMANT Address Mrs. John Barnes, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration Pneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH > 6 wks 1 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		20g. (County) Washington	
21. I certify that I attended the deceased from Oct. 5th , 19 57 , to Dec 12th , 19 57 , that I last saw the deceased alive on Dec 12th , 19 57 , and that death occurred at 8 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St. Hagerstown Md. DATE SIGNED Dec 12/1957							
ACTUAL SIGNATURE <i>[Signature]</i>		PHYSICIAN'S NAME (Type) Dr. [Signature]					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-14-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Super-Pouzer Funeral Home				24a. REC'D BY REGISTRAR Dec 17 1957		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13647

Reg. Dist. No. 302

13637

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>8 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1100 West Washington St</u>				d. STREET ADDRESS <u>1100 West Washington St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>JOSEPH</u> Last <u>BEACH</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28 1904</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Beach</u>				14. MOTHER'S MAIDEN NAME <u>Susan Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>171-14-3052</u>		17. INFORMANT Address <u>Mrs Catherine Beach 1100 West Wash. St Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Label Memorial Chapel Cemetery Hagerstown</u>		22d. LOCATION (City, town, or county) (State) <u>Rockingham Co Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 23 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

13648
302

13694

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE NEW YORK b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BOONSBORO				c. LENGTH OF STAY IN 1b 2 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FARNEY KEEDY MEMORIAL HOME				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SARANAC LAKE			
				d. STREET ADDRESS I RIVERSIDE DRIVE			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA JOSEPHINE BENDELL				4. DATE OF DEATH Month Day Year 12 27 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8, 1875		9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ALBANY N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MATTHEW SLAVIN				14. MOTHER'S MAIDEN NAME ELLEN SLOAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ALFRED S. BENDELL JR.		Address HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Vascular Collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/26/57 , 19 57 , to 12/27 , 19 57 , that I last saw the deceased alive on 12/26 , 19 57 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam DATE SIGNED 12/28/57 ACTUAL SIGNATURE Louis G. Graff M.D. Hagerstown PHYSICIAN'S NAME (Type) Louis G. GRAFF MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 29, 1957		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL		22d. LOCATION (City, town, or county) (State) HAGERSTOWN, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR Dec. 30, 1957	
				24b. REGISTRAR'S SIGNATURE Black, Powers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

2 JAN 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13649

13695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring c. LENGTH OF STAY IN lb 2 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 2		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Clearspring d. STREET ADDRESS Route 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Franklin Last Bennett		4. DATE OF DEATH Month 12 Day 4 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1926
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 31	IF UNDER 24 HRS. Days 4 Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	
11. BIRTHPLACE (State or foreign country) Cumberland Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl Bennett		14. MOTHER'S MAIDEN NAME Agnes Kline	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 219-20-1652	
17. INFORMANT Mrs. Ruth Bennett		Address Clearspring, Md. R2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anexia due to ethonal and methonal poisoning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mentally ill			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drank Zerone	
20c. TIME OF INJURY Month, Day, Year about Dec. 3 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Rural Clearspring, Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) burial		22b. DATE THEREOF 12-7-57	
22c. NAME OF CEMETERY OR CREMATORY ST. PAULS		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		24a. REC'D BY REGISTRAR Dec 9-57	
ADDRESS Clearspring, Md.		24b. REGISTRAR'S SIGNATURE Joseph W. Murray	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		35		M		W		1957		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		EXAMINER'S SIGNATURE	
1234 5th Ave.		Clerk		Heart Disease		Natural		1234		J. J. Jones	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
1922		New York		High School		Married		None		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION		EXAMINER'S NAME		EXAMINER'S TITLE		EXAMINER'S SIGNATURE		EXAMINER'S ADDRESS	
1957		New York		J. J. Jones		Medical Examiner		J. J. Jones		1234 5th Ave.	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWER'S NAME		INTERVIEWER'S TITLE		INTERVIEWER'S SIGNATURE		INTERVIEWER'S ADDRESS	
1957		New York		J. J. Jones		Medical Examiner		J. J. Jones		1234 5th Ave.	
DATE OF REPORT		PLACE OF REPORT		REPORTER'S NAME		REPORTER'S TITLE		REPORTER'S SIGNATURE		REPORTER'S ADDRESS	
1957		New York		J. J. Jones		Medical Examiner		J. J. Jones		1234 5th Ave.	

BUREAU V. E.

DEC 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Bell

13638

CERTIFICATE OF DEATH

13650

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Hagerstown R#6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE MAY Middle BERGER Last		4. DATE OF DEATH Month Dec. Day 12 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1883
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Funkstown-Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David G. Barnhardt		14. MOTHER'S MAIDEN NAME Virginia Fry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Pauline A. Price-375 Belvidere Av.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Years.		INTERVAL BETWEEN ONSET AND DEATH 17 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 360X Diabetes Mellitus for 6 years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 26, 1957, to Dec. 12, 1957, that I last saw the deceased alive on Dec. 12, 1957, and that death occurred at 9:00P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) 119 N. Potomac Street, DATE SIGNED 12-14-57	
PHYSICIAN'S NAME (Type) R. A. Bell, M. D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/57	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Leitersburg-Wash. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		24a. REC'D BY REGISTRAR Dec. 16, 1957 24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "1912-03-15"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935-08-10"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
TIME OF DEATH [Faint text, possibly "10:15 AM"]		DATE OF DEATH [Faint text, possibly "1957-12-18"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]	

BUREAU V. 2

DEC 18 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown	
c. LENGTH OF STAY IN 1b 3 weeks		d. STREET ADDRESS 101 E. Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Othe Middle J Last Bierley		4. DATE OF DEATH Month 12 Day 12 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Policeman	
11. BIRTHPLACE (State or foreign country) Funkstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob H. Bierley		14. MOTHER'S MAIDEN NAME Mary Ellen Leckrone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Eva Kesselring		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO CHRONIC PYELONEPHRITIS 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease& Gen. art.-sclerosis (c) Pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 12/3/57
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked cystitis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 16 1957 , to December 12 1957 , that I last saw the deceased alive on December 11 1957 , and that death occurred at 12:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Funkstown, Maryland DATE SIGNED 12/13/57			
ACTUAL SIGNATURE Sidney Novenstein M.D.		PHYSICIAN'S NAME (Type) S. Novenstein, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-14-57	22c. NAME OF CEMETERY OR CREMATORY Funkstown	22d. LOCATION (City, town, or county) (State) Funkstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Dec 13 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		COUNTY OF BALTIMORE	
NAME OF DECEASED [Illegible]		SEX [Illegible]	
AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]		CAUSE OF DEATH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

DEC 16 1957

RECEIVED

13696 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 307

13652

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Cumberland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsburg</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>		d. STREET ADDRESS <u>----</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ANN BOBB</u>		4. DATE OF DEATH Month Day Year <u>December 30 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Huntsberger</u>		14. MOTHER'S MAIDEN NAME <u>Cynthia Ann Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Homewood Church Home Records Williamsport Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO <u>-----</u> (c) <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-1-1956</u> , to <u>12-30-1957</u> , that I last saw the deceased alive on <u>12-25-57</u> , 19 <u>57</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>12/31/57</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>		M.D. <u>[Signature]</u> <u>1/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-3-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestnut Hill Cemetery</u>	22d. LOCATION (City, town, or county) <u>Mechanicsburg Cumberland Co Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

JAN 2 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13653

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion</u>		75 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gateway Convalescent Home</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Garnet H.</u> First Middle Last		4. DATE OF DEATH <u>Dec. 17, 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher- R.R. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Ann Kuhn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-07-9342</u>	
17. INFORMANT <u>Mrs. Sallie Bowman, Marion, Penna.</u>		Address <u>Franklin Co. Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of Left leg</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Sclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>10 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1, 1957</u> to <u>Dec. 17, 1957</u> , that I last saw the deceased alive on <u>Dec. 16, 1957</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>David R. Brewer</u> M.D. PHYSICIAN'S NAME (Type) <u>David R. Brewer Clear Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 20, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Norland Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Kauffman</u>		24. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	
40 East Antietam St. Hagerstown, Md.		24a. REG'D BY REGISTRAR DATE <u>DEC 23 1957</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MRS. J. M. BROWN		2. SEX F		3. AGE 65		4. DATE OF BIRTH JAN 15 1892	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION HOUSEWIFE		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE JUN 10 1915	
9. PLACE OF DEATH BALTIMORE, MARYLAND		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. DATE OF DEATH DEC 28 1956	
13. SIGNATURE OF PHYSICIAN J. M. BROWN		14. SIGNATURE OF FUNERAL HOME J. M. BROWN		15. SIGNATURE OF WITNESSES J. M. BROWN		16. SIGNATURE OF DECEASED J. M. BROWN	
17. NAME OF FUNERAL HOME J. M. BROWN		18. ADDRESS OF FUNERAL HOME J. M. BROWN		19. CITY OF FUNERAL HOME BALTIMORE, MARYLAND		20. STATE OF FUNERAL HOME MARYLAND	
21. NAME OF NEXT OF KIN J. M. BROWN		22. ADDRESS OF NEXT OF KIN J. M. BROWN		23. CITY OF NEXT OF KIN BALTIMORE, MARYLAND		24. STATE OF NEXT OF KIN MARYLAND	
25. NAME OF BURIAL PLACE J. M. BROWN		26. ADDRESS OF BURIAL PLACE J. M. BROWN		27. CITY OF BURIAL PLACE BALTIMORE, MARYLAND		28. STATE OF BURIAL PLACE MARYLAND	
29. NAME OF CEMETERY J. M. BROWN		30. ADDRESS OF CEMETERY J. M. BROWN		31. CITY OF CEMETERY BALTIMORE, MARYLAND		32. STATE OF CEMETERY MARYLAND	
33. NAME OF INTERVIEWER J. M. BROWN		34. ADDRESS OF INTERVIEWER J. M. BROWN		35. CITY OF INTERVIEWER BALTIMORE, MARYLAND		36. STATE OF INTERVIEWER MARYLAND	
37. NAME OF REPORTER J. M. BROWN		38. ADDRESS OF REPORTER J. M. BROWN		39. CITY OF REPORTER BALTIMORE, MARYLAND		40. STATE OF REPORTER MARYLAND	
41. NAME OF REGISTRAR J. M. BROWN		42. ADDRESS OF REGISTRAR J. M. BROWN		43. CITY OF REGISTRAR BALTIMORE, MARYLAND		44. STATE OF REGISTRAR MARYLAND	
45. NAME OF CLERK J. M. BROWN		46. ADDRESS OF CLERK J. M. BROWN		47. CITY OF CLERK BALTIMORE, MARYLAND		48. STATE OF CLERK MARYLAND	
49. NAME OF ASSISTANT J. M. BROWN		50. ADDRESS OF ASSISTANT J. M. BROWN		51. CITY OF ASSISTANT BALTIMORE, MARYLAND		52. STATE OF ASSISTANT MARYLAND	
53. NAME OF CHIEF J. M. BROWN		54. ADDRESS OF CHIEF J. M. BROWN		55. CITY OF CHIEF BALTIMORE, MARYLAND		56. STATE OF CHIEF MARYLAND	
57. NAME OF DEPUTY J. M. BROWN		58. ADDRESS OF DEPUTY J. M. BROWN		59. CITY OF DEPUTY BALTIMORE, MARYLAND		60. STATE OF DEPUTY MARYLAND	
61. NAME OF SECRETARY J. M. BROWN		62. ADDRESS OF SECRETARY J. M. BROWN		63. CITY OF SECRETARY BALTIMORE, MARYLAND		64. STATE OF SECRETARY MARYLAND	
65. NAME OF ASSISTANT SECRETARY J. M. BROWN		66. ADDRESS OF ASSISTANT SECRETARY J. M. BROWN		67. CITY OF ASSISTANT SECRETARY BALTIMORE, MARYLAND		68. STATE OF ASSISTANT SECRETARY MARYLAND	
69. NAME OF CLERK J. M. BROWN		70. ADDRESS OF CLERK J. M. BROWN		71. CITY OF CLERK BALTIMORE, MARYLAND		72. STATE OF CLERK MARYLAND	
73. NAME OF ASSISTANT J. M. BROWN		74. ADDRESS OF ASSISTANT J. M. BROWN		75. CITY OF ASSISTANT BALTIMORE, MARYLAND		76. STATE OF ASSISTANT MARYLAND	
77. NAME OF CHIEF J. M. BROWN		78. ADDRESS OF CHIEF J. M. BROWN		79. CITY OF CHIEF BALTIMORE, MARYLAND		80. STATE OF CHIEF MARYLAND	
81. NAME OF DEPUTY J. M. BROWN		82. ADDRESS OF DEPUTY J. M. BROWN		83. CITY OF DEPUTY BALTIMORE, MARYLAND		84. STATE OF DEPUTY MARYLAND	
85. NAME OF SECRETARY J. M. BROWN		86. ADDRESS OF SECRETARY J. M. BROWN		87. CITY OF SECRETARY BALTIMORE, MARYLAND		88. STATE OF SECRETARY MARYLAND	
89. NAME OF ASSISTANT SECRETARY J. M. BROWN		90. ADDRESS OF ASSISTANT SECRETARY J. M. BROWN		91. CITY OF ASSISTANT SECRETARY BALTIMORE, MARYLAND		92. STATE OF ASSISTANT SECRETARY MARYLAND	
93. NAME OF CLERK J. M. BROWN		94. ADDRESS OF CLERK J. M. BROWN		95. CITY OF CLERK BALTIMORE, MARYLAND		96. STATE OF CLERK MARYLAND	
97. NAME OF ASSISTANT J. M. BROWN		98. ADDRESS OF ASSISTANT J. M. BROWN		99. CITY OF ASSISTANT BALTIMORE, MARYLAND		100. STATE OF ASSISTANT MARYLAND	

BUREAU V. S.

DEC 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13640

CERTIFICATE OF DEATH

13654

Reg. Dist. No. 302

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>Franklin</u> ✓	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hagerstown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u>		TOWN <u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garlock Mem. Conv. Hospital</u>				STREET ADDRESS (If rural give location) <u>State Line, Pa.</u>			
3. NAME OF DECEASED (Type or Print) <u>DESSIE B. BREWBAKER</u>				4. DATE OF DEATH <u>Dec. 16 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>5/8/1869</u>	
9. AGE last birthday <u>88</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		11. BIRTHPLACE (State or foreign country) <u>Antrim Twp., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Kuhn</u>				14. MOTHER'S MAIDEN NAME <u>Esther Eby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mary E. Smith - State Line</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral hemorrhage</u>				<u>1 wk</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>				<u>years</u>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Dec</u> , 19 <u>57</u> , to <u>16 Dec</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 Dec</u> , 19 <u>57</u> , and that death occurred at <u>12:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>P. E. Smith</u> M.D.				ADDRESS (Street, city, town, state) <u>Greencastle, Pa.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/19/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>	
24. REC'D BY REGISTRAR <u>Dec 19 1957</u>		REGISTRAR'S SIGNATURE <u>Blair Bowers</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Winnich</u>		ADDRESS <u>Greencastle Pa.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John A. Smith*

2. SEX: *Male*

3. AGE: *65*

4. OCCUPATION: *Retired*

5. PLACE OF BIRTH: *Baltimore, Md.*

6. DATE OF DEATH: *Dec 23 1957*

7. TIME OF DEATH: *10:30 AM*

8. CAUSE OF DEATH: *Heart Disease*

9. PLACE OF DEATH: *Home*

10. SIGNATURE OF PHYSICIAN: *John A. Smith*

11. SIGNATURE OF REGISTRAR: *John A. Smith*

12. SIGNATURE OF WITNESS: *John A. Smith*

BUREAU V. R.

DEC 23 1957

RECEIVED

13698

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SMITHSBURG RURAL				c. LENGTH OF STAY IN 1b 25 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SMITHSBURG MD. ROUTE 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES D. BRUNNER				4. DATE OF DEATH Month Day Year DECEMBER 23 1957 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 9 1889 68 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL FARMING NEAR WOLFESBURG		11. BIRTHPLACE (State or foreign country) FRED. CO. MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME DANIEL BRUNNER			
14. MOTHER'S MAIDEN NAME MARTHA WITMER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT MRS. LAURA W. BRUNNER SMITHSBURG MD. R. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-18 , 19 57 , to 12-23 , 19 57 , that I last saw the deceased alive on 12-23 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 12/24/57							
ACTUAL SIGNATURE Charles F. Hess M.D.				PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 26 1957		22c. NAME OF CEMETERY OR CREMATORY MT. LENA CEMETERY		22d. LOCATION (City, town, or county) (State) MT. LENA WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE DEC 31 '57	
24b. REGISTRAR'S SIGNATURE Al. Leach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

S. Robert Wells, Jr. #3641
DME Wash. Co

CERTIFICATE OF DEATH

13656
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>16 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. county hospital</u>				e. STREET ADDRESS <u>1009 Main Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>EDGAR</u> Last <u>CARBAUGH</u>				4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David R. Carbaugh</u>				14. MOTHER'S MAIDEN NAME <u>Marie King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-7983</u>		17. INFORMANT <u>David C. Carbaugh 658 N Prospect St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>492X</u> (b) <u>Pneumonia L. Base</u> (c) <u>Fracture Left Humerus 12-1-57</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11-10-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Humerus 12-1-57</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>5:55</u> p. m.	Month <u>12</u>	Day <u>1</u>	Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hagerstown Md</u>	20f. (City or town) <u>Hagerstown Md</u>	(County) (State)
21. I certify that I attended the deceased from <u>Nov. 29, 1957</u> to <u>Dec 1, 1957</u> that I last saw the deceased alive on <u>Dec 1 - 1957</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sidney Novenstein</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown Md</u>			
DATE SIGNED <u>12-4-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec. 17, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Health Officers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH - BULLETIN 12
 CERTIFICATE OF DEATH

NAME OF DECEASED [Faint, illegible text]		SEX [Faint, illegible text]		AGE [Faint, illegible text]	
PLACE OF BIRTH [Faint, illegible text]		DATE OF BIRTH [Faint, illegible text]		TIME OF BIRTH [Faint, illegible text]	
PLACE OF DEATH [Faint, illegible text]		DATE OF DEATH [Faint, illegible text]		TIME OF DEATH [Faint, illegible text]	
CAUSE OF DEATH [Faint, illegible text]		MANNER OF DEATH [Faint, illegible text]		PLACE OF INTERMENT [Faint, illegible text]	
SIGNATURE OF PHYSICIAN [Faint, illegible text]		SIGNATURE OF REGISTRAR [Faint, illegible text]		SIGNATURE OF WITNESS [Faint, illegible text]	

RECEIVED
 DEC 20 1957
 BUREAU V. S.

13642 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13657
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Aloysius</u> Last <u>Cashman</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 5, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Round House Form.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. M. R. R. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Shamokin, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John Cashman</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Healey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>705-10-5973</u>				17. INFORMANT <u>Mrs. Edward A. Cashman, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach with metastasis</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Oct. 29</u> , 19 <u>57</u> , to <u>Dec. 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>December 6</u> , 19 <u>57</u> , and that death occurred at <u>11:55M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington Street</u> DATE SIGNED <u>12/9/57</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u> M.D.							
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John P. ...</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

DEC 11 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13658

13643

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>Wesley</u> Last <u>Clipp</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 21 1898</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor Farm</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Experimental Farm W. Va.</u>		11. BIRTHPLACE (State or foreign country) <u>Charlestown W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>David W. Clipp</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Huff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 26 7912</u>		17. INFORMANT Address <u>Church Street Sharpsburg Maryland</u> <u>Mrs. Ethel Clipp</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X Hypertension Rt. Kidney & liver - 2 Mo</u> DUE TO <u>fat embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>	Month, <u></u> Day, <u></u> Year <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>10/11/57</u> 19 <u>57</u> to <u>12/11/57</u> 19 <u>57</u> that I last saw the deceased alive on <u>12/11/57</u> 19 <u>57</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>William Street Md</u> DATE SIGNED <u>12/13/57</u> ACTUAL SIGNATURE <u>Joseph F. Young</u> M.D. PHYSICIAN'S NAME (Type) <u>Albert L. Wolf Williamsport Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Wolf Williamsport Md</u>				24a. REC'D BY REGISTRAR <u>Dec. 16. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

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BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13644 CERTIFICATE OF DEATH

Reg. Dist. No.

13659
302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 122 POTOMAC STREET			
3. NAME OF DECEASED (Type or print) JESSE BROWN CLIPP				4. DATE OF DEATH DECEMBER 16 1957 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 27 1881	
9. AGE (In years last birthday) 76 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL FARMING		11. BIRTHPLACE (State or foreign country) SHARPSBURG WASH.CO.MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN RANDOLPH CLIPP			
14. MOTHER'S MAIDEN NAME ELIZABETH HOFFMASTER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT MRS. NELDA CLIPP BOONSBORO MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombus of the right popliteal artery 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 week. 5 Yr. plus
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis with left hemiplegia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 2, 1957 to Dec. 16, 1957 , that I last saw the deceased alive on Dec. 16, 1957 , and that death occurred at 10:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sharpsburg, Md. DATE SIGNED 12/18/57							
ACTUAL SIGNATURE Walter H. Shealy M.D.				PHYSICIAN'S NAME (Type) Walter H. Shealy M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 19 1957		22c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		22d. LOCATION (City, town, or county) (State) SHARPSBURG WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Best Funeral Home ADDRESS Boonsboro Md.				24a. REC'D BY REGISTRAR Dec. 21 1957		24b. REGISTRAR'S SIGNATURE Chas. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES V. S.		M		45		JAN 15 1912		BALTIMORE, MARYLAND	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE	
JAMES V. S.		JAN 15 1912		JAN 15 1912		JAN 15 1912		JAN 15 1912	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 15 1957		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		LABORER	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF INTERMENT		NAME OF MINISTER		NAME OF CLERGYMAN	
JAN 15 1957		BALTIMORE, MARYLAND		JAMES V. S.		JAMES V. S.		JAMES V. S.	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF BURIAL		NAME OF MINISTER		NAME OF CLERGYMAN	
JAN 15 1957		BALTIMORE, MARYLAND		JAMES V. S.		JAMES V. S.		JAMES V. S.	

BUREAU V. S.

DEC 9 1957

RECEIVED

13699

CERTIFICATE OF DEATH

Reg. Dist. No.

13660

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EAKLES MILL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EAKLES MILL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KEEDYSVILLE MD. ROUTE 1				d. STREET ADDRESS KEEDYSVILLE MD. ROUTE 1			
3. NAME OF DECEASED (Type or print) First DORIS Middle JUNE Last CORDER				4. DATE OF DEATH Month DECEMBER Day 12 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17 1927		9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) EAKLES MILL WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUSSEL CORDER				14. MOTHER'S MAIDEN NAME MOSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. RUSSEL CORDER KEEDYSVILLE MD. ROUTE 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Idiot DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days 30 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 11 , 19 57 , to Dec 12 , 19 57 , that I last saw the deceased alive on Dec 11 , 19 57 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. HeVan				ADDRESS (Street, city or town, state) Boonsboro Md		DATE SIGNED 12/14/57	
PHYSICIAN'S NAME (Type) G. W. HeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 15 1957		22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East-June How				ADDRESS Boonsboro Md		24a. REC'D BY REGISTRAR DATE Dec. 16 57	
				24b. REGISTRAR'S SIGNATURE Boonsboro Md			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13661

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>132 Nottingham Road</u>				d. STREET ADDRESS <u>132 Nottingham Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUSSELL</u> Middle <u>EUGENE</u> Last <u>CRAIG</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1957</u>		9. AGE (In years last birthday) yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ollen O. Craig</u>				14. MOTHER'S MAIDEN NAME <u>Lillian S. Marquiss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Ollen O. Craig 132 Nottingham Rd. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) - - -			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>S. Robert Wells M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>12-27-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rest Haven Funeral Chapel Inc. 1601 Penna. Ave.</u>				24a. REC'D BY REGISTRAR <u>Dec 28, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Powers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Wm. C. Horst W.P. Hagerstown, Md. 4000376XV6

BUREAU V. E.

13646

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) First John Middle Snively Last Cunningham		4. DATE OF DEATH Month December Day 18 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Treasurer		10b. KIND OF BUSINESS OR INDUSTRY Livestock Co.	
11. BIRTHPLACE (State or foreign country) Bakersville Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. Cunningham		14. MOTHER'S MAIDEN NAME M. Florence Snively	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. 214-09-8932	
17. INFORMANT W. W. Cunningham		Address Hag Rt. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/25 , 19 56 , to 12/18 , 19 57 , that I last saw the deceased alive on 12/18 , 19 57 , and that death occurred at 2 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Campbell		ADDRESS (Street, city or town, state) Hagerstown Md.	
PHYSICIAN'S NAME (Type) 145 W Washington St		DATE SIGNED 12/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-20-57	22c. NAME OF CEMETERY OR CREMATORY Bakersville Cemetery	22d. LOCATION (City, town, or county) (State) Bakersville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Dec 22, 1957		24b. REGISTRAR'S SIGNATURE Phyllis H. Bowers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• *Investor's*

Journal of Management Education 26(8)

W 5297-05413

BUREAU V. S.

DEC 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13647

CERTIFICATE OF DEATH

Reg. Dist. No. 302

13663

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2208 Virginia Ave</u>		d. STREET ADDRESS <u>2203 Virginia Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>KATE</u> Last <u>DASHER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. McGusker</u>		14. MOTHER'S MAIDEN NAME <u>Martha E. Rowland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ephram E. Miller 2003 Virginia Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-1-</u> , 19 <u>57</u> , to <u>12-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12-5-</u> , 19 <u>57</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md.</u>	
DATE SIGNED <u>12/7/57</u>		M.D. <u> </u>	
PHYSICIAN'S NAME (Type) <u>DR F W HITT</u>		<u>Hagerstown Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
SEX		AGE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
EDUCATION		RELIGION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
SIGNED AND SWORN TO before me this _____ day of _____, 19____		by _____		at _____		in the presence of _____		and _____	
My commission expires _____		Notary Public for the State of New York		at _____		in the presence of _____		and _____	

BUREAU V. S.

DEC 11 1957

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

13664

1. PLACE OF DEATH o. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>5 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>922 Lanvale Street</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>922 Lanvale Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TIMOTHY</u> First <u>LEE</u> Middle <u>DRIGGERS</u> Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 7, 1957</u> 9. AGE (In years last birthday) yrs. <u>5</u> Months <u>15</u> Days <u>15</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>December 22 1957</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Lindo Driggers, Jr.</u> 14. MOTHER'S MAIDEN NAME <u>Shirley Mae Humphrey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mr. Lindo Driggers, Jr.</u> Address <u>Hagerstown, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of vomitus</u> <u>759.3</u> DUE TO <u>Congenital hypoplasia of adrenal glands</u> Conditions, if any, which gave rise to immediate cause (b) <u>Congenital hyperplasia of Thymus glands</u> (a), stating the underlying cause lost. DUE TO <u>Infected Excoriation of buttocks</u> (c) <u>EXCORIATION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None 19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> 20f. (City or town) (County) (State) <u>- - -</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>12-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>12/26/1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Suter-Rouzer Funeral Home Hagerstown, Md.</u> <u>R. Franklin Rouzer</u> 24a. REC'D BY REGISTRAR <u>Dec. 27, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>	

VS. A15ME
5M 2/57

2081182XV3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1211

BUREAU A. S.

DEC 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13649 CERTIFICATE OF DEATH

13665

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 Weeks</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>1 1060 Dual Place</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ANNA</u> Last <u>DYCHE</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Robinette</u>				14. MOTHER'S MAIDEN NAME <u>MARY ROBINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Margaret Spickler 730 W. Wash St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Myocarditis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>5 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u>19</u> Month <u>12</u> Day <u>4</u> Year <u>1957</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>57</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Harrison</u>			ADDRESS (Street, city or town, state) <u>318 N. Potomac St Hagerstown Md</u>			DATE SIGNED <u>12-5-57</u>	
PHYSICIAN'S NAME (Type) <u>PAUL HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 7 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas H. Roovers</u>			

CERTIFICATE OF DEATH

Page No. 1

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED	
22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED	
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31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED	
34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
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40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
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49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED	
52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED	
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64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
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73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED	
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79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED	
82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
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94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED	
100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

BUREAU V. S.

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13650

CERTIFICATE OF DEATH

Reg. Dist. No.

13666
204

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #6 WESTMINSTER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS RT. #6 06X22	
3. NAME OF DECEASED (Type or print) First SPICIE Middle ELKINS Last ELKINS		4. DATE OF DEATH Month DEC. Day 10 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 17, 1980
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEKEEPING	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ELKINS		14. MOTHER'S MAIDEN NAME Ardie Bernard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. ISRAEL ELKINS (SON) - SAME.	
17. INFORMANT Address ISRAEL ELKINS (SON) - SAME.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X TERMINAL BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL VASCULAR ACCIDENT DUE TO (c) HYPERTENSION & GENERALISED ARTERIOSELEROSIS		INTERVAL BETWEEN ONSET AND DEATH 16 HOURS 10 YRS. 10 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MALNUTRITION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC. 5 , 19 57 , to DEC. 10 , 19 57 , that I last saw the deceased alive on DEC. 10 , 19 57 , and that death occurred at 10.05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1500 PENNSYLVANIA AVE. DATE SIGNED 12/10/57			
ACTUAL SIGNATURE George BerCU		M.D. 1500 PENNSYLVANIA AVE.	
PHYSICIAN'S NAME (Type) DR. G. BERCU		HAGERSTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-12-57	22c. NAME OF CEMETERY OR CREMATORY Westerly	22d. LOCATION (City, town, or county) (State) WESTMINSTER MD
23. FUNERAL DIRECTOR'S SIGNATURE H BANKARIT + SON		ADDRESS WESTMINSTER	
24a. REC'D BY REGISTRAR DEC 12 1957		24b. REGISTRAR'S SIGNATURE Chris Bowers	

BUREAU V. F.

DEC 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13667

13651 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 643 Pennsylvania Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MADALYN Middle RUTH Last EVANS		4. DATE OF DEATH Month Dec. Day 3 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1905
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 2 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stores Dept.		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft	
11. BIRTHPLACE (State or foreign country) Garrett Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George J. Poole		14. MOTHER'S MAIDEN NAME Gertrude Harvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-20-3956	
17. INFORMANT Mr. Mernie S. Evans		Address 643 Penna. Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver's cirrhosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2-4 months 4+ months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1957, to Dec 3 , 1957, that I last saw the deceased alive on Dec 2 , 1957, and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert F. Keadle M.D.		DATE SIGNED Hagerstown Md Dec 4, 1957	
PHYSICIAN'S NAME (Type) Robert F. Keadle M.D.		318 N. Potomac St. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/57	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave.		24. REC'D BY REGISTRAR Dec 5, 1957	
24b. REGISTRAR'S SIGNATURE W. H. Keadle			

BUREAU V. S.

DEC 9 1957

RECEIVED

13652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS Rural 2 Hancock Md.	
3. NAME OF DECEASED (Type or print) First Archiball Middle W Last Everts		4. DATE OF DEATH Month 12 Day 19 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8.6.1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 4 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming and Orchard		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Everts		14. MOTHER'S MAIDEN NAME Dorothy Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Joseph M Everts Chambersburg Penna.	
17. INFORMANT Joseph M Everts Chambersburg Penna.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 17 , 19 57 , to December 18 , 19 57 , that I last saw the deceased alive on Dec. 18 , 19 57 , and that death occurred at 8:40 P.M. from the causes and on the date stated above. Dr. F.J. Hirshman saw deceased 12/19/57 . ADDRESS (Street, city or town, state) DATE SIGNED 100 Professional Arts Bldg. 12/20/57 ACTUAL SIGNATURE Dr. F.J. Hirshman, M.D. M.D. 100 Professional Arts Bldg. 12/20/57 PHYSICIAN'S NAME (Type) William T. Layman , Hagerstown , Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12.21.57	22c. NAME OF CEMETERY OR CREMATOR Rehobeth Methodist	22d. LOCATION (City, town, or county) (State) Near Hancock Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Shaw Hancock Md		24a. REC'D BY REGISTRAR Dec 24 1957 24b. REGISTRAR'S SIGNATURE Blair H. Powers	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13653 CERTIFICATE OF DEATH

13669

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 Week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS Western Pike			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WALTER Middle HAYS Last FRUSH				4. DATE OF DEATH Month December Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 13 1876		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md. Clear Spring Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Frush				14. MOTHER'S MAIDEN NAME Martha A. Repp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Alma A. Frush Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 561.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Strangulated Inguinal Hernia DUE TO (c) Operated on Dec. 7, 1957						INTERVAL BETWEEN ONSET AND DEATH Sudden 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operated on Dec. 7, 1957						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 7, 1957 , to Dec 15, 1957 , that I last saw the deceased alive on Dec. 14, 1957 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city or town, state) Box 166		DATE SIGNED	
PHYSICIAN'S NAME (Type) David R. Brewer				Clear Spring Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57		22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery near Clear Spring Wash Co Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR Dec. 20, 1957		24b. REGISTRAR'S SIGNATURE Thy H. [Signature]	

MAINE STATE DEPARTMENT OF HEALTH - BATHING 10 1957 CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION		13. PRESENT ADDRESS		14. DATE OF ENTRY INTO STATE		15. DATE OF DEPARTURE FROM STATE		16. DATE OF RETURN TO STATE	
17. CAUSE OF DEATH		18. MANNER OF DEATH		19. PLACE OF DEATH		20. TIME OF DEATH		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF DECEASED	
25. NAME OF PHYSICIAN		26. NAME OF REGISTRAR		27. NAME OF WITNESSES		28. NAME OF DECEASED		29. NAME OF NEXT OF KIN		30. NAME OF FUNERAL HOME		31. NAME OF BURIAL PLACE		32. NAME OF CEMETERY	

BUREAU V. S.

DEC 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Smithsburg</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 rural Smithsburg</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD 2</u>				d. STREET ADDRESS <u>1 RFD 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mark</u> Middle <u>Westley</u> Last <u>Garnand</u>				4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>19 57</u>				
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Myersville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>		
13. FATHER'S NAME <u>Ezra Garnand</u>				14. MOTHER'S MAIDEN NAME <u>Arbanna Baker</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-24-9548</u>		17. INFORMANT Address <u>Gavin Garnand, Smithsburg, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>12-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Welty's Cemetery</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Smithsburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 31 '57</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		
22d. LOCATION (City, town, or county) <u>Greensburg, Md.</u>				22e. (State) <u> </u>				

RECEIVED

DEC 31 1957

BUREAU V. 2

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
NAME OF DECEASED JAMES J. HARRIS	
DATE OF DEATH 12-28-57	
PLACE OF DEATH 1000 1st Ave. New York 17, N.Y.	
AGE 45	
SEX Male	
RACE White	
EDUCATION High School	
OCCUPATION Salesman	
MARRIAGE Married	
RELIGION Catholic	
CAUSE OF DEATH Myocardial Infarction	
MANNER OF DEATH Natural	
SIGNATURE OF MEDICAL EXAMINER J. J. HARRIS	
DATE 12-28-57	
PLACE New York	
COUNTY New York	
CITY New York	
STATE New York	
ZIP CODE 10001	
FEDERAL BUREAU OF INVESTIGATION U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C. 20535	

13701 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA ELIZABETH GLOSS</u>				4. DATE OF DEATH Month Day Year <u>Dec 7 1957</u> 19 <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 6 1870</u>	
9. AGE (In years last birthday) yrs. <u>87</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Wash. Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jacob Myers</u>				14. MOTHER'S MAIDEN NAME <u>Anna Catherine Cookerly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs Anna R. Emmert</u>				Address <u>56 Broadway Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7 yrs</u> DUE TO (c) <u>7 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-1-57</u> 19 <u>57</u> , to <u>12-7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12-5</u> 19 <u>57</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. F. W. Dittus Jr.</u> M.D. <u>Hagerstown Md.</u> <u>12-7-57</u>							
PHYSICIAN'S NAME (Type) <u>Dr. F. W. Dittus Jr.</u> <u>Hagerstown Md.</u> <u>12-7-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Christa Bowers</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

FILE NO. 84

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. JONES		35		M		W		1922		BALTIMORE, MARYLAND	
MARRIAGE		DATE		PLACE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		1945		BALTIMORE		JANE M. JONES		1957		BALTIMORE	
OCCUPATION		DATE		PLACE		NAME OF EMPLOYER		DATE OF DEATH		PLACE OF DEATH	
LABORER		1950		BALTIMORE		BALTIMORE STEEL CO.		1957		BALTIMORE	
EDUCATION		DATE		PLACE		NAME OF SCHOOL		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		1940		BALTIMORE		BALTIMORE CITY SCHOOL		1957		BALTIMORE	
RELIGION		DATE		PLACE		NAME OF CHURCH		DATE OF DEATH		PLACE OF DEATH	
METHODIST		1945		BALTIMORE		METHODIST CHURCH		1957		BALTIMORE	
CAUSE OF DEATH		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		1957		BALTIMORE		DR. J. M. JONES		1957		BALTIMORE	
MANNER OF DEATH		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
NATURAL		1957		BALTIMORE		JOHN M. JONES		1957		BALTIMORE	
SIGNATURE OF CORONER		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JOHN M. JONES		1957		BALTIMORE		DR. J. M. JONES		1957		BALTIMORE	
SIGNATURE OF PHYSICIAN		DATE		PLACE		NAME OF CORONER		DATE OF DEATH		PLACE OF DEATH	
DR. J. M. JONES		1957		BALTIMORE		JOHN M. JONES		1957		BALTIMORE	
SIGNATURE OF WITNESS		DATE		PLACE		NAME OF PHYSICIAN		DATE OF DEATH		PLACE OF DEATH	
JANE M. JONES		1957		BALTIMORE		DR. J. M. JONES		1957		BALTIMORE	

BUREAU V. S.

DEC 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

13654

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 24 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00117 BELVIEW AVENUE				d. STREET ADDRESS SHARPSBURG WASH.CO.MD.R 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JOHN W. HOLMES				4. DATE OF DEATH Month Day Year DECEMBER 24 1957 19			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 22 1876 81 yrs.	
9. AGE (In years lost birthday) 81		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) SAMPLES MANOR WASH.CO.MD. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM HOLMES				14. MOTHER'S MAIDEN NAME MARY HAHN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 722-18-7532		17. INFORMANT HOWARD L. HOLMES 117 BELVIEW AVENUE HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/24 , 19 57 , to 12/24/57 , 19 57 , that I last saw the deceased alive on 12/24 , 19 57 , and that death occurred at 10:10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert Vh Campbell M.D.				ADDRESS (Street, city or town, state) 145 W Washington St			
DATE SIGNED 12/27/57							
PHYSICIAN'S NAME (Type) Robert V. H. Campbell				Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		DEC. 28 1957		SAMPLES MANOR CEMETERY		SAMPLES MANOR WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR Dec. 28. 1957	
				24b. REGISTRAR'S SIGNATURE Robert V. H. Campbell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the funeral director. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Robert V. Campbell</i>		2. SEX <i>Male</i>		3. AGE <i>62</i>	
4. DATE OF DEATH <i>12/24/1967</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
10. SIGNATURE OF REGISTRAR <i>[Signature]</i>		11. DATE OF REGISTRATION <i>12/24/1967</i>		12. OFFICIAL SEAL <i>[Seal]</i>	

BUREAU V. 2

DEC 31 1967

RECEIVED

Vertical text on the right margin, likely a filing or processing stamp, partially illegible.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13655

CERTIFICATE OF DEATH

Reg. Dist. No.

13673

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Rural - Clearspring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nelson</u> First <u>Elwood</u> Middle <u>Horst</u> Last				4. DATE OF DEATH <u>Dec. 24</u> Month <u>24</u> Day <u>19</u> Year <u>57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1951</u> 9. AGE (In years lost birthday) <u>6</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Horst</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Martin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Amos Horst</u> Address <u>RD-1 Clearspring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Glomerulonephritis, onset 590x</u> DUE TO							<u>5 WKS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>After Acute tonsillitis & upper</u> DUE TO							
(c) <u>Respiratory Infection</u>							<u>1 WK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 6</u> , 1957, to <u>Dec 24</u> , 1957, that I last saw the deceased alive on <u>Dec 24</u> , 1957, and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward W. Dittmann</u> M.D.				ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>12/24/57</u>			
PHYSICIAN'S NAME (Type) <u>Edward W. Dittmann M.D.</u>				<u>Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clearspring Mennonite Cem - Clearspring, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Minnich - Greencastle, Pa.</u>				24a. REC'D BY REGISTRAR <u>Dec. 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Gowers</u>	

CERTIFICATE OF DEATH

W-10-1

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	



BUREAU V. M.

JEC 30 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13656

CERTIFICATE OF DEATH

Reg. Dist. No.

13674

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>55 E. Franklin St.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANCIS HOVIS</u>		4. DATE OF DEATH Month Day Year <u>December 11, 19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman-West. Md. R.R.-Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Lewistown-Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Hovis</u>		14. MOTHER'S MAIDEN NAME <u>Mary Flanagan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-4766</u>	
17. INFORMANT Address <u>Mrs. Ruth Hovis-55 E. Franklin St.-Hag.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1-56</u> , 19 <u>56</u> , to <u>12-11-1957</u> , that I last saw the deceased alive on <u>12-9-57</u> , 19 <u>57</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. E. W. Sells</u>		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>12/13/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. Sells</u>		M.D. <u>Hagerstown Md</u> <u>12/13/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown-Wash. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>		ADDRESS <u>Thurmont, Fred Co. Md</u>	
24a. REC'D BY REGISTRAR <u>Dec 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the funeral director to attend the deceased.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

13675

304

Reg. Dist. No.

13702

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WASHINGTON</u>		STATE <u>MD.</u> COUNTY <u>WASHINGTON</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>HANCOCK</u>		LENGTH OF STAY (in this place) <u>7 yrs</u>		TOWN <u>HANCOCK</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VIRGINIA</u> (Middle) <u>R.</u> (Last) <u>HOYLE</u>				(Month) <u>Dec.</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>AUG. 19 1872</u>	<u>85</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSEWIFE</u>				<u>MORGAN Co., W. Va.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN W. SHADE</u>				<u>MARY C. MILLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>						<u>Mrs. Carrie Pryor - Hancock, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 11-28</u> , 19 <u>57</u> , to <u>Dec 11-28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-28</u> , 19 <u>57</u> , and that death occurred at <u>2:15</u> P. M. from the causes and on the date stated above.							
SIGNATURE <u>Herbert R Tobias</u>				ADDRESS (Street, city, town, state) <u>Berkeley Springs, W. Va.</u>			
DATE <u>12-11-57</u>				DATE SIGNED <u>12-10-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-11-57</u>		<u>BETHEL</u>		<u>MORGAN Co., W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12/11/57</u>		<u>J. A. Neller</u>		<u>John J. Hunter</u>		<u>BERKELEY SPRINGS, W. VA.</u>	

CERTIFICATE OF DEATH

1937

DEPT. OF HEALTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF CLERK

23. SIGNATURE OF DEPUTY CHIEF CLERK

24. SIGNATURE OF RECORDS CLERK

25. SIGNATURE OF CLERK OF SUPERIOR COURT

26. SIGNATURE OF CLERK OF DISTRICT COURT

27. SIGNATURE OF CLERK OF PROBATE COURT

28. SIGNATURE OF CLERK OF NOTARY PUBLIC

29. SIGNATURE OF CLERK OF JUDICIAL DEPARTMENT

30. SIGNATURE OF CLERK OF LEGISLATIVE DEPARTMENT

31. SIGNATURE OF CLERK OF EXECUTIVE DEPARTMENT

32. SIGNATURE OF CLERK OF FINANCIAL DEPARTMENT

33. SIGNATURE OF CLERK OF AGRICULTURE

34. SIGNATURE OF CLERK OF EDUCATION

35. SIGNATURE OF CLERK OF LABOR

36. SIGNATURE OF CLERK OF COMMERCE

37. SIGNATURE OF CLERK OF TRANSPORTATION

38. SIGNATURE OF CLERK OF PUBLIC WORKS

39. SIGNATURE OF CLERK OF FIRE DEPARTMENT

40. SIGNATURE OF CLERK OF POLICE DEPARTMENT

41. SIGNATURE OF CLERK OF SHERIFF'S DEPARTMENT

42. SIGNATURE OF CLERK OF JAIL DEPARTMENT

43. SIGNATURE OF CLERK OF PRISON DEPARTMENT

BUREAU V. S.

DEC 16 1937

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13657

13676

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
f. STREET ADDRESS <u>249 1/2 Summit Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>-</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Printing Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rudolph Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Robert S. Johnson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized</u> <u>420.1</u> DUE TO <u>acute Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12-14-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg Mont Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec. 16/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Shartt Powers</u>	

BUREAU V. S.

DEC 18 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13677

13658

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Funkstown</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>7</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John William Johnson</u>				4. DATE OF DEATH Month Day Year <u>December 8 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 7, 1871</u>		9. AGE (In years last birthday) yrs. <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Mfg. Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>William Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Ann Lowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-09-9405</u>		17. INFORMANT Address <u>Mrs. John Helmer Funkstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>145 W Washington St</u>		
20f. (City or town) <u>Hagerstown Md.</u>			20g. (County) <u>Hagerstown</u>			20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>July 55</u> , 19 <u>55</u> , to <u>Dec 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 8</u> , 19 <u>57</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. H. Campbell</u>				DATE SIGNED <u>12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. H. Campbell</u>				<u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Funkstown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Funkstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>				ADDRESS <u>Hag. Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 11, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Blair Powers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE, MD.	
MARRIED		11		11		11		11		11	
EDUCATION		HIGH SCHOOL		GRADUATE		PROFESSOR		TEACHER		CLERK	
OCCUPATION		PROFESSOR		TEACHER		CLERK		LABORER		FARMER	
DATE OF DEATH		11		11		11		11		11	
PLACE OF DEATH		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF WITNESS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF DECEASED		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

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DEC 18 1957
BUREAU V. E.

13703

CERTIFICATE OF DEATH

Reg. Dist. No.

1367805

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Boonsboro</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fahrney Keedy Memorial Home</u>				d. STREET ADDRESS <u>Middletown 10 X 2.2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie Ellen Kefauver</u>				4. DATE OF DEATH Month Day Year <u>12 28 19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/26/1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>D. Edward Kefauver</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Louise Weagley, Middletown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Glycerin</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arthritis + arteriosclerosis</u> DUE TO (c) <u>Longevity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>hr</u> <u>yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/26/57</u> , 19 <u>57</u> , to <u>12/28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/26</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Louis G. Griffe</u> M.D.				<u>119 E. Antietam</u> <u>12/28/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Louis G. Griffe</u>				<u>18 Middletown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/30/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Co., Middletown, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 31 1957</u> 24b. REGISTRAR'S SIGNATURE <u>John H. Back</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 31 1957

RECEIVED

13659 CERTIFICATE OF DEATH

Reg. Dist. No.

13679
302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		d. STREET ADDRESS 424 GEORGE ST.	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last KNODE		4. DATE OF DEATH Month I2 Day IO Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 10, 1895
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT MALOTT		14. MOTHER'S MAIDEN NAME Georgetta Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-09-7740	
17. INFORMANT MISS HELEN KNODE		Address 424 GEORGE ST. HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intermittent heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with congestive failure DUE TO (c) (Decompensation)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pneumonia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 1, 1956 , to Dec 10, 1957 , that I last saw the deceased alive on Dec 10, 1957 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Dittman		ADDRESS (Street, city or town, state) DATE SIGNED 817 W. Washington St. 12/12/57	
PHYSICIAN'S NAME (Type) Edward W. Dittman, MD		HAGERSTOWN MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-13-57	22c. NAME OF CEMETERY OR CREMATORY Antietam National	22d. LOCATION (City, town, or county) (State) Sharpsburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS		ADDRESS HAGERSTOWN MD.	
24a. REC'D BY REGISTRAR Dec 13, 1957		24b. REGISTRAR'S SIGNATURE Shart, Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13660 CERTIFICATE OF DEATH

Reg. Dist. No.

13680✓

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Maryland</u> X2			
d. STREET ADDRESS <u>216 Chaplain St. Sharpsburg</u> Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>Leslie</u> Last <u>Koontz</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 31 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stockman in Shop</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. Railroad</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Clinton Koontz</u>				14. MOTHER'S MAIDEN NAME <u>Willa Mina Showe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-10-5448</u>			
17. INFORMANT <u>Mrs. Mabel Koontz</u>				Address <u>216 Chaplain St. Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic (coronary) Heart Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				20g. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>12/19, 1957</u> , to <u>12/29, 1957</u> , that I last saw the deceased alive on <u>12/29, 1957</u> , and that death occurred at <u>7:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u> DATE SIGNED <u>1-2-58</u>							
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D. <u>154 West Washington St., Hagerstown, Md.</u> DATE SIGNED <u>1-2-58</u>							
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Sharpsburg Maryland</u>				(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				ADDRESS <u>Williamsport, Md.</u>		24. REG'D BY REGISTRAR <u>JAN 3 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Chris H. Bowers</u>				DATE <u></u>			

BUREAU V. S.

3 856

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13681307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md	c. LENGTH OF STAY IN lb 45 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Washington County Hospital		d. STREET ADDRESS 401 N. Jonathan Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Wilbert Frank Latney	4. DATE OF DEATH Month Day Year Dec. 28 19 57		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bell Boy		10b. KIND OF BUSINESS OR INDUSTRY Hotel	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank Latney		14. MOTHER'S MAIDEN NAME Mary Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-0673	17. INFORMANT Wilbert Latney, Jr -401 N. Jonathan St- Hagerstown, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X Acute coronary occlusion DUE TO (b) Vascular hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Luetic myocardial heart disease 8yrs			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		DATE SIGNED 12-30-57	
22a. BURIAL, CREMATION, REMOVAL Burial	22b. DATE THEREOF 12-31-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John R. Watson		ADDRESS Hagerstown Md JAN 3 1958	

FOR STATE
HEALTH DEPT

3883

MARY AND STATE DEPT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 3 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13662

CERTIFICATE OF DEATH

Dr Waddell

Reg. Dist. No.

13682

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>110 Greenmount Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>LAWSON</u> Last <u>LAWSON</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 23 1957</u>	
9. AGE (In years last birthday) <u>770.0</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Larry Lawson</u>		14. MOTHER'S MAIDEN NAME <u>Judith Foltz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Larry Lawson 110 Greenmount Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis Fetalis</u> DUE TO <u>Rh Sensitization</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-----</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/23/</u> 19 <u>57</u> , to <u>12/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12/23/</u> 19 <u>57</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon Jr</u>		M.D. <u>Hagerstown, Md.</u>		ADDRESS (Street, city or town, state) <u>302 N. Polomace St.</u>		DATE SIGNED <u>12/24/57</u>	
PHYSICIAN'S NAME (Type) <u>-----</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12 24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Dec 27 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Black, Howard</u>	

2081191XV5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

BUREAU V. 1

REC 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mennonite Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hagerstown	
3. NAME OF DECEASED (Type or print) First Middle Last LeRoy Kieffer Lehman		4. DATE OF DEATH Month Day Year Dec. 2, 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. store	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Lehman		14. MOTHER'S MAIDEN NAME Mary Ellen Middlekauff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-26-0822	
17. INFORMANT D. L. Sneckenberger, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease. 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 mo. 2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 8, 1957, to Dec. 2, 1957, that I last saw the deceased alive on Dec. 2, 1957, and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. A. Bell		ADDRESS (Street, city or town, state) DATE SIGNED 119 N. Potomac St. 12-3-57.	
PHYSICIAN'S NAME (Type) R. A. Bell, M.D.		119 N. Potomac St., Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-4-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 5, 1957	
24b. REGISTRAR'S SIGNATURE Charles H. Rogers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

DEC 9 1957

RECEIVED

George F. Minnich & Son, Hagerstown, Md. 17033

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13705

CERTIFICATE OF DEATH

13684

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>4 3/4 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VICTOR</u> <u>E.</u> <u>LINDER</u>		4. DATE OF DEATH Month Day Year <u>Dec.</u> <u>4</u> <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spotter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Linder</u>		14. MOTHER'S MAIDEN NAME <u>Mary Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-4756</u>	
17. INFORMANT <u>Mrs. Betty S. Gruber</u>		Address <u>416 Jefferson St. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Spine</u> <u>196x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Dec 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3 Dec</u> , 19 <u>57</u> , and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Haak</u> M.D.		ADDRESS (Street, city or town, state) <u>28 W. Patomac St. Williamsport, Md.</u>	
DATE SIGNED <u>4 Dec 57</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Host UP</u>		ADDRESS <u>Hagerstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Powers</u>	

BUREAU V. S.

DEC 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13685
302

Reg. Dist. No.

13706

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HAGERSTOWN RFD#4</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HAGERSTOWN</u> d. STREET ADDRESS <u>HAGERSTOWN RFD#4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>JEAN</u> Middle <u>JOANN</u> Last <u>LOVELESS</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1957</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 5, 1953</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>4</u> yrs. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u></u> Min. <u></u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>WASH. Co. Hospital Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>CECIL LOVELESS</u>				14. MOTHER'S MAIDEN NAME <u>HELEN ZIMMERMAN</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>RFD#4</u> <u>MR CECIL LOVELESS HAGERSTOWN, MD</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute gastro-enteritis</u> DUE TO <u>aspirated vomitus and died during convulsive seizure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> <u>Convulsions due to sub-dural hemorrhage (old)</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>									
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 19-57</u>									
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>Dec. 20, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAKERSVILLE Cem.</u>		22d. LOCATION (City, town, or county) <u>BAKERSVILLE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Loveless</u>				ADDRESS <u>Williamport, Md</u>				24a. REC'D BY REGISTRAR <u>Dec 21. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 26 1957
BUREAU V. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13707

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN lb 37 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 rural Smithsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rd #2			d. STREET ADDRESS Rd #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Paul Middle Henry Last Martin			4. DATE OF DEATH Month Dec. Day 28 Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1900		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker		10b. KIND OF BUSINESS OR INDUSTRY city gov.		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.	
12. CITIZEN OF WHAT COUNTRY					
13. FATHER'S NAME Abraham Martin			14. MOTHER'S MAIDEN NAME Elizabeth Shank		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-07-8696		17. INFORMANT Address A. James Martin, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x Gun shot wound thru skull into brain DUE TO Hemorrhage and shock Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with .22 cal. rifle			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 Dec. 28 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Rural Smithsburg, Wash, Md		20g. (County) Wash.		20h. (State) Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-30-57	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-31-57		22c. NAME OF CEMETERY OR CREMATORY Cavetown Cemetery	
22d. LOCATION (City, town, or county) Cavetown, Md.		22e. (State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Scott F. Minnich & Son, Hagerstown, Md.			24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE JAN 2 1958		

RECEIVED

JAN 2 1958

BUREAU V. S.

13663

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELEANOR First CYNTHIA Middle MATTHEWS Last				4. DATE OF DEATH Month December Day 15 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1907	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 1 Days 22		IF UNDER 24 HRS. Hours 1 Min. 22			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elmira, New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Ray Brown				14. MOTHER'S MAIDEN NAME Katie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 093-20-3703		17. INFORMANT Mr. Howard E. Matthews Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 12, 1957 to Dec 15, 1957 , that I last saw the deceased alive on Dec 15, 1957 , and that death occurred at 3 4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul Harrison				ADDRESS (Street, city or town, state) 318 North Potomac St DATE SIGNED 12-16-57			
PHYSICIAN'S NAME (Type) PAUL HARRISON				Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/16/1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouzer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 17, 1957	
				24b. REGISTRAR'S SIGNATURE Thas H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 19 1957

RECEIVED

13708

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>7 months 2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. STREET ADDRESS <u>518 Stratford Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>MAE</u> Last <u>MAUK</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 28, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Romney Hampshire Co., W. VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Isaac Pultz</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shantholtz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Virginia Bell</u> Address <u>641 Highland Way Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>600.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pyelonephritis, bilateral</u> DUE TO <u>10 months</u> (c) <u>-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Primary anemia (macrocytic)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov. 1948</u> , to <u>Dec. 3, 1957</u> , that I last saw the deceased alive on <u>Oct 29, 1957</u> , and that death occurred at <u>5:35 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 W. Washington</u> DATE SIGNED <u>12/3/57</u>							
ACTUAL SIGNATURE <u>George Jennings</u>				M.D. <u>Hagerstown, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George Jennings</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Indian Mound Cemetery Romney Hampshire Co W. Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. McElroy</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

13664 CERTIFICATE OF DEATH

13689

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
f. STREET ADDRESS 518 W. Franklin Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EMMITT First EARLY Middle MAXEY Last				4. DATE OF DEATH December Month 18 Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1887	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 11 Days 8 Hours Min. 		11. IF UNDER 24 HRS. Months Days Hours Min. 		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Near Dillwyn, Virginia			
13. FATHER'S NAME Horatio Maxey				14. MOTHER'S MAIDEN NAME Ella O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. I 228-01-3641		17. INFORMANT Mrs. Mae Maxey		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR Collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) arteriosclerosis - Hypertension INTERVAL BETWEEN ONSET AND DEATH Min 2 days Yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1955 , 19, to Dec 18 , 19 57 , that I last saw the deceased alive on 12-17 , 19 57 , and that death occurred at 6:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 S. Antietam DATE SIGNED 12/18/57 ACTUAL SIGNATURE Louis G Graef M.D. Louis G Graef PHYSICIAN'S NAME (Type) Louis G GRAEF Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/21/1957		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Blue Field, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Franklin Ringer				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 20, 1957	
24b. REGISTRAR'S SIGNATURE Chas H Bowers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13665

CERTIFICATE OF DEATH Dr. Lusby

Reg. Dist. No.

13690

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Counth Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman Ralph McClelland</u>				4. DATE OF DEATH Month Day Year <u>Dec. 21 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Cty</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. McClelland</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mrs. Helen B. McClelland, 321 N. Mulberry</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-Sclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 1953</u> 19 <u>53</u> , to <u>21 Dec</u> 19 <u>57</u> , that I last saw the deceased alive on <u>21 Dec</u> 19 <u>57</u> , and that death occurred at <u>5:55 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F F Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac</u>		DATE SIGNED <u>22 Dec 57</u>	
PHYSICIAN'S NAME (Type) <u>F F Lusby</u>				<u>Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-24-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 27. 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>	

RECEIVED

DEC 30 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

13666

CERTIFICATE OF DEATH

Reg. Dist. No.

207

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W. Va.</u> b. COUNTY <u>Morgan</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>413 Robin Wood Drive</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Berkeley Springs</u> X1			
f. STREET ADDRESS <u>Cherry Run</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Caroline McCullough</u>				4. DATE OF DEATH Month Day Year <u>Dec. 7, 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 28, 1885</u>	
9. AGE (In years lost birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>9</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William M. Newcomer</u>				14. MOTHER'S MAIDEN NAME <u>EMMA FUNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Harold H. McCullough, Hagerstown, Md. 413 Robin Wood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema & plant effusion</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>yes</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/15/57</u> , 19 <u>57</u> , to <u>12/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/2</u> , 19 <u>57</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.				ADDRESS (Street, city or town, state) <u>136 N. Calmar</u>			
DATE SIGNED <u>12/6/57</u>							
PHYSICIAN'S NAME (Type) <u>HOWARD N. WEEKS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Berkeley Springs, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PARKS FUNERAL HOME</u> <u>R.E. Parks</u>				ADDRESS <u>Berkeley Springs, W. Va.</u>		24a. REC'D BY REGISTRAR <u>DEC 11 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 11 1957

RECEIVED

13692
303

13667

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>13 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>836 Spruce Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Mc Elroy</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12 1877</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Section Gang Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md</u>		11. BIRTHPLACE (State or foreign country) <u>Downsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Mc Elroy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-4841</u>		17. INFORMANT <u>Mrs. Charles Barnhart</u>		Address <u>836 Spruce St. Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/14/57</u> to <u>12/15/57</u> , that I last saw the deceased alive on <u>12/15/57</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Williamsport Maryland</u> DATE SIGNED <u>12/15/57</u> ACTUAL SIGNATURE <u>Ralph F. Young</u> M.D. <u>William J. Hart</u> PHYSICIAN'S NAME (Type) <u>Albert L. Lee Williamsport, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Lee Williamsport, Md</u>				24a. REC'D BY REGISTRAR <u>Dec 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13669 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13693
Reg. Dist. No. 302

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia 25x-3	
c. LENGTH OF STAY IN 1b 5 days		d. STREET ADDRESS 148 N. 8th St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hotel Alexander		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roger First Roselle Middle McKay Last		4. DATE OF DEATH Month December Day 8 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1897
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) psychiatric aid		10b. KIND OF BUSINESS OR INDUSTRY hospital	
11. BIRTHPLACE (State or foreign country) Sheridan, Michigan		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Frank A. McKay		14. MOTHER'S MAIDEN NAME Harriet Hyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. 350-05-9002	
17. INFORMANT Newton Baker VA Center, Martinsburg, W. Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Thoracic vertebrae ; Multiple fractured ribs; Fracture of lt. humerus; Multiple fractures of pelvis; lt femur, tibia, and fibula; hemorrhage and shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 978x DUE TO (c) 978x</p> </div> <div style="width: 50%;"> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None</p> </div> </div>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from 9th floor Hotel room and landed on coffee shop roof	
20c. TIME OF INJURY Month, Day, Year 6:30 a.m. Dec. 8 19 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hotel Building	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-9-57	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-12-57	22b. DATE THEREOF 12-12-57	22c. NAME OF CEMETERY OR CREMATORIAL Rock Hill Cemetery - Arlington Nat. Cem.	22d. LOCATION (City, town, or county) (State) Hagerstown, Md. Ft. Meyer, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 11 1957	
		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FBI STATE

STATE DEPARTMENT OF HEALTH - BALTIMORE 18
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

DEC 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13694

Dr. Robt. Campbell 13709 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#6		c. LENGTH OF STAY IN TB 2½ yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paramount		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Hagerstown R#6	
3. NAME OF DECEASED (Type or print) First Middle Last EVA CORNELIA MIDDLEKAUFF		4. DATE OF DEATH Month Day Year December 9, 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1869
9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Gearfoss-Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Wolfensberger		14. MOTHER'S MAIDEN NAME Eva Kuhn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Pauline Palmer-331 Liberty St.-Hagers.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 19, 1913 , to Dec. 9, 1957 , that I last saw the deceased alive on Dec. 9, 1957 , and that death occurred at 8:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED L. L. Packer Jr. M.D. 145 W. Washington St. 12/9/57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) L. L. Packer Jr. Hagerstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-57	
22c. NAME OF CEMETERY OR CREMATORY Salem E&R Cemetery		22d. LOCATION (City, town, or county) (State) nr. Gearfoss-Wash. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS Dec. 12, 1957	
24a. REC'D BY REGISTRAR Dec. 12, 1957		24b. REGISTRAR'S SIGNATURE Chas H. Bowers	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13695

13710

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 12 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		e. STREET ADDRESS Route 1	
3. NAME OF DECEASED (Type or print) Helen Jane Miller		4. DATE OF DEATH Month December Day 14 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1866
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (State or foreign country) Near Boonesboro Md.		14. CITIZEN OF WHAT COUNTRY?	
15. FATHER'S NAME Benjamin H. Gigeous		16. MOTHER'S MAIDEN NAME Amanda Thomas	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		18. SOCIAL SECURITY NO. -	
19. INFORMANT Dr. R. S. Snavelly		Address Hag. Rt. 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 422.1 DUE TO arteriosclerotic myocardial heart failure grade iv Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None Bronchial Asthma			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Dec 19 1957		24b. REGISTRAR'S SIGNATURE Chas H. Brown	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County Washington		Age 15 years		Sex Male	
Race Negro		Married Single		Occupation Student	
Residence 1215 1/2 St. N.E.		Date of Death Dec. 18, 1957		Time of Death 10:30 P.M.	
Cause of Death		Immediate Cause		Underlying Cause	
Died at Home		Died at Hospital		Died at Other Place	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner	

BUREAU V. S.

DEC 23 1957

RECEIVED

Robert Wells R. D.
Rose Hill Cemetery
12-18-57
Sect. 1. Minion & Son, Hagerstown, Md.

CERTIFICATE OF DEATH

13696

Reg. Dist. No.

302

13669

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 15 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PATSY Middle RUTH Last MILLER		4. DATE OF DEATH Month DECEMBER Day 2 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/11/1931
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY FURNITURE STORE	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME PAUL V. MILLER		14. MOTHER'S MAIDEN NAME ALICE FRENCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		17. INFORMANT Address HAGERSTOWN MD.	
16. SOCIAL SECURITY NO. 217-28-1273		17. INFORMANT MRS. ALICE F. MILLER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Aplastic Anemia 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO			INTERVAL BETWEEN ONSET AND DEATH 2 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 23, 1957 , to Dec 2, 1957 , that I last saw the deceased alive on Dec 2, 1957 , and that death occurred at 3:48 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington Street DATE SIGNED 12/3/57			
ACTUAL SIGNATURE Edward W. Ditto III M.D.		DATE SIGNED 12/3/57	
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL, SPECIAL BURIAL	22b. DATE THEREOF 12/4/57	22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 5 1957	24b. REGISTRAR'S SIGNATURE Phyllis H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 9 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES J. JONES	
2. SEX Male	
3. AGE 45	
4. DATE OF BIRTH JAN 15 1912	
5. PLACE OF BIRTH NEW YORK	
6. OCCUPATION Salesman	
7. CAUSE OF DEATH Myocardial Infarction	
8. PLACE OF DEATH Home	
9. DATE OF DEATH DEC 8 1957	
10. SIGNATURE OF DECEASED (None)	
11. SIGNATURE OF WITNESSES (None)	
12. SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)	
13. SIGNATURE OF DECEASED'S PHYSICIAN (None)	
14. SIGNATURE OF DECEASED'S MINISTER OF RELIGION (None)	
15. SIGNATURE OF DECEASED'S BURIAL OFFICER (None)	
16. SIGNATURE OF DECEASED'S FUNERAL HOME (None)	
17. SIGNATURE OF DECEASED'S CEMETERY (None)	
18. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
19. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
20. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
21. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
22. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
23. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
24. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
25. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
26. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
27. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
28. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
29. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
30. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
31. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
32. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
33. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
34. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
35. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
36. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
37. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
38. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
39. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
40. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
41. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
42. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
43. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
44. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
45. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
46. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
47. SIGNATURE OF DECEASED'S BURIAL DATE (None)	
48. SIGNATURE OF DECEASED'S BURIAL PLACE (None)	
49. SIGNATURE OF DECEASED'S BURIAL TIME (None)	
50. SIGNATURE OF DECEASED'S BURIAL DATE (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration or prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

13670

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. Sh. County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
f. STREET ADDRESS <u>36 East Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WARPHY SAMUEL MILLER</u>		4. DATE OF DEATH Month Day Year <u>December 8 1957 19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Shiloh Wash Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian Miller</u>		14. MOTHER'S MAIDEN NAME <u>Anna Daugherty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Vergie B. Miller</u>		Address <u>36 East Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>General Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>332X</u> DUE TO (c) <u>Rheumatoid Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 28, 1957</u> to <u>Dec. 8, 1957</u> , that I last saw the deceased alive on <u>Dec. 8, 1957</u> , and that death occurred at <u>11 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		ADDRESS (Street, city or town, state) <u>159 W. Washington St. Hagerstown Md.</u>	
DATE SIGNED <u>12/9/57</u>			
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Dec. 12, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

BUREAU V. S.

DEC 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13671

CERTIFICATE OF DEATH

Reg. Dist. No. 302

13698

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Hagerstown b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
f. STREET ADDRESS 216 Jefferson Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ELLSWORTH Last MINER		4. DATE OF DEATH Month December Day 30 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 4, 1887
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 26 Hours Min. 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Organ Builder		10b. KIND OF BUSINESS OR INDUSTRY Organ Factory	
11. BIRTHPLACE (State or foreign country) Near Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN Henry Miner		14. MOTHER'S MAIDEN NAME Sarah Jane Bowman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-6231	
17. INFORMANT Mrs. Iva. B. Miner		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X general peritonitis - primary DUE TO lesion probably in tail of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pancreas DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 6 Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prognosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 4, 1957 , to Dec 30, 1957 , that I last saw the deceased alive on Dec 30, 1957 , and that death occurred at 4:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward W. Ditto III		DATE SIGNED 12/31/57	
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/1958	
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24. REGISTRAR'S SIGNATURE Chas. A. Bowers	
ADDRESS Hagerstown, Md.		DATE JAN 3 1958	

CERTIFICATE OF DEATH

1967

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

BUREAU V. 8

JAN 3 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13741 CERTIFICATE OF DEATH

13699

Reg. Dist. No. 200

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>				c. LENGTH OF STAY IN 1b <u>91 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main Street</u>				d. STREET ADDRESS <u>Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Mose</u> Last <u>Mose</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11 1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Jacob Mose</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ellen Poffenbarger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Ellen L Keyfauver Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric hemorrhage</u> DUE TO Generalized carcinomatosis - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary focus unknown - probably prostate</u> DUE TO unknown. (c) <u>Basal cell epitheliomas of the neck and head - 20 years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Basal cell epitheliomas of the neck and head - 20 years</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Dec. 3</u> 19 <u>57</u> , to <u>Dec. 6</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 3</u> 19 <u>57</u> , and that death occurred at <u>4:30A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter H. Shealy</u> M.D.				ADDRESS (Street, city or town, state) <u>Sharpsburg, Md.</u>		DATE SIGNED <u>Dec. 6, 1957</u>	
PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williams, Md</u>				24a. REC'D BY REGISTRAR DATE <u>Dec 7-57</u>		24b. REGISTRAR'S SIGNATURE <u>E. G. Boyer</u>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Wm. J. Thompson

BUREAU V. 5

DEC 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13672

CERTIFICATE OF DEATH

13700
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 03			
c. LENGTH OF STAY IN 1b 5 Yrs				d. STREET ADDRESS 1 West Wilson Blvd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 West Wilson Blvd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Albert WELLINGTON Moser				4. DATE OF DEATH Month Day Year Dec. 16 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23 1882	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Moser				14. MOTHER'S MAIDEN NAME Amanda Weddle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Nannie W. Moser 1 West Wilson Blvd Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Indefinite						INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 6 , 19 55 to Dec. 16 , 19 57 , that I last saw the deceased alive on Dec. 16 , 19 57 , and that death occurred at 5:55P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 148 West Washington St. 12/17/57							
ACTUAL SIGNATURE B. B. Kneisley		M.D. 148 West Washington St. 12/17/57					
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/57	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR Dec 20, 1957		24b. REGISTRAR'S SIGNATURE Chas H Bowser	

CERTIFICATE OF DEATH

15073

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1922		MOBILE, ALABAMA		APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

DEC 23 1957

RECEIVED

13673 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN lb <u>48 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Mowen</u> Last <u>Mowen</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-25-1876</u>	
9. AGE (In years lost birthday) <u>81 yrs.</u>		10. AGE (In years lost birthday) <u>1</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>John Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Mary ELIZABETH BANKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Thurman Mowen, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19 Aug.</u> 19 <u>57</u> , to <u>13 Dec.</u> 19 <u>57</u> , that I last saw the deceased alive on <u>12 Dec.</u> 19 <u>57</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard T. Binford</u> M.D.				ADDRESS (Street, city or town, state) <u>1135 Patmore Ave Hagerstown, Md.</u>			
DATE SIGNED <u>14 Dec 57</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mercersburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mercersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u>				ADDRESS <u>Hagerstown Md</u>		24a. REC'D BY REGISTRAR <u>Dec 17, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEWLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

File No. 100-100000

<p>1. NAME OF DECEASED JOHN DOE</p>		<p>2. SEX MALE</p>	
<p>3. AGE 45</p>		<p>4. RACE WHITE</p>	
<p>5. DATE OF BIRTH JAN 15 1912</p>		<p>6. PLACE OF BIRTH BALTIMORE, MD</p>	
<p>7. DATE OF DEATH DEC 10 1957</p>		<p>8. PLACE OF DEATH BALTIMORE, MD</p>	
<p>9. TIME OF DEATH 10:00 AM</p>		<p>10. CAUSE OF DEATH HEART DISEASE</p>	
<p>11. MANNER OF DEATH NATURAL</p>		<p>12. SIGNATURE OF DECEASED (None)</p>	
<p>13. SIGNATURE OF WITNESSES (None)</p>		<p>14. SIGNATURE OF DECEASED (None)</p>	
<p>15. SIGNATURE OF DECEASED (None)</p>		<p>16. SIGNATURE OF DECEASED (None)</p>	
<p>17. SIGNATURE OF DECEASED (None)</p>		<p>18. SIGNATURE OF DECEASED (None)</p>	
<p>19. SIGNATURE OF DECEASED (None)</p>		<p>20. SIGNATURE OF DECEASED (None)</p>	
<p>21. SIGNATURE OF DECEASED (None)</p>		<p>22. SIGNATURE OF DECEASED (None)</p>	
<p>23. SIGNATURE OF DECEASED (None)</p>		<p>24. SIGNATURE OF DECEASED (None)</p>	
<p>25. SIGNATURE OF DECEASED (None)</p>		<p>26. SIGNATURE OF DECEASED (None)</p>	
<p>27. SIGNATURE OF DECEASED (None)</p>		<p>28. SIGNATURE OF DECEASED (None)</p>	
<p>29. SIGNATURE OF DECEASED (None)</p>		<p>30. SIGNATURE OF DECEASED (None)</p>	
<p>31. SIGNATURE OF DECEASED (None)</p>		<p>32. SIGNATURE OF DECEASED (None)</p>	
<p>33. SIGNATURE OF DECEASED (None)</p>		<p>34. SIGNATURE OF DECEASED (None)</p>	
<p>35. SIGNATURE OF DECEASED (None)</p>		<p>36. SIGNATURE OF DECEASED (None)</p>	
<p>37. SIGNATURE OF DECEASED (None)</p>		<p>38. SIGNATURE OF DECEASED (None)</p>	
<p>39. SIGNATURE OF DECEASED (None)</p>		<p>40. SIGNATURE OF DECEASED (None)</p>	
<p>41. SIGNATURE OF DECEASED (None)</p>		<p>42. SIGNATURE OF DECEASED (None)</p>	
<p>43. SIGNATURE OF DECEASED (None)</p>		<p>44. SIGNATURE OF DECEASED (None)</p>	
<p>45. SIGNATURE OF DECEASED (None)</p>		<p>46. SIGNATURE OF DECEASED (None)</p>	
<p>47. SIGNATURE OF DECEASED (None)</p>		<p>48. SIGNATURE OF DECEASED (None)</p>	
<p>49. SIGNATURE OF DECEASED (None)</p>		<p>50. SIGNATURE OF DECEASED (None)</p>	
<p>51. SIGNATURE OF DECEASED (None)</p>		<p>52. SIGNATURE OF DECEASED (None)</p>	
<p>53. SIGNATURE OF DECEASED (None)</p>		<p>54. SIGNATURE OF DECEASED (None)</p>	
<p>55. SIGNATURE OF DECEASED (None)</p>		<p>56. SIGNATURE OF DECEASED (None)</p>	
<p>57. SIGNATURE OF DECEASED (None)</p>		<p>58. SIGNATURE OF DECEASED (None)</p>	
<p>59. SIGNATURE OF DECEASED (None)</p>		<p>60. SIGNATURE OF DECEASED (None)</p>	
<p>61. SIGNATURE OF DECEASED (None)</p>		<p>62. SIGNATURE OF DECEASED (None)</p>	
<p>63. SIGNATURE OF DECEASED (None)</p>		<p>64. SIGNATURE OF DECEASED (None)</p>	
<p>65. SIGNATURE OF DECEASED (None)</p>		<p>66. SIGNATURE OF DECEASED (None)</p>	
<p>67. SIGNATURE OF DECEASED (None)</p>		<p>68. SIGNATURE OF DECEASED (None)</p>	
<p>69. SIGNATURE OF DECEASED (None)</p>		<p>70. SIGNATURE OF DECEASED (None)</p>	
<p>71. SIGNATURE OF DECEASED (None)</p>		<p>72. SIGNATURE OF DECEASED (None)</p>	
<p>73. SIGNATURE OF DECEASED (None)</p>		<p>74. SIGNATURE OF DECEASED (None)</p>	
<p>75. SIGNATURE OF DECEASED (None)</p>		<p>76. SIGNATURE OF DECEASED (None)</p>	
<p>77. SIGNATURE OF DECEASED (None)</p>		<p>78. SIGNATURE OF DECEASED (None)</p>	
<p>79. SIGNATURE OF DECEASED (None)</p>		<p>80. SIGNATURE OF DECEASED (None)</p>	
<p>81. SIGNATURE OF DECEASED (None)</p>		<p>82. SIGNATURE OF DECEASED (None)</p>	
<p>83. SIGNATURE OF DECEASED (None)</p>		<p>84. SIGNATURE OF DECEASED (None)</p>	
<p>85. SIGNATURE OF DECEASED (None)</p>		<p>86. SIGNATURE OF DECEASED (None)</p>	
<p>87. SIGNATURE OF DECEASED (None)</p>		<p>88. SIGNATURE OF DECEASED (None)</p>	
<p>89. SIGNATURE OF DECEASED (None)</p>		<p>90. SIGNATURE OF DECEASED (None)</p>	
<p>91. SIGNATURE OF DECEASED (None)</p>		<p>92. SIGNATURE OF DECEASED (None)</p>	
<p>93. SIGNATURE OF DECEASED (None)</p>		<p>94. SIGNATURE OF DECEASED (None)</p>	
<p>95. SIGNATURE OF DECEASED (None)</p>		<p>96. SIGNATURE OF DECEASED (None)</p>	
<p>97. SIGNATURE OF DECEASED (None)</p>		<p>98. SIGNATURE OF DECEASED (None)</p>	
<p>99. SIGNATURE OF DECEASED (None)</p>		<p>100. SIGNATURE OF DECEASED (None)</p>	

BUREAU V. B.

DEC 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										13702
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 1029 Concord St.					
3. NAME OF DECEASED (Type or print) First John Middle James Last Myers					4. DATE OF DEATH Month Dec. Day 15 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17, 1937		9. AGE (In years last birthday) 20 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier			10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Hanover, Penna			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George C. Myers					14. MOTHER'S MAIDEN NAME Dorothea Penelope Daugherty					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-34-7667		17. INFORMANT Address Mr. Geo. C. Myers 1029 Concord St. Hagerstown, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undetermined yet Intra-cerebral hemorrhage</u> 816x DUE TO Carotid Sinus reflex (Whip lash type of injury) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Shock DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile involved in auto collision							
20c. TIME OF INJURY Hour 10 p.m. Month, Day, Year Dec. 14 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Hagerstown		20g. (County) Wash		
								20h. (State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE S. Robert Wells					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) S. Robert Wells, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					12-16-57
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Wm. G. Stant & Son					ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Dec 17 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 20 1957
BUREAU V. E.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE	
22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF GUARD	
25. SIGNATURE OF WARDEN		26. SIGNATURE OF CHIEF OF POLICE		27. SIGNATURE OF DETECTIVE	
28. SIGNATURE OF INSPECTOR		29. SIGNATURE OF SARGENT		30. SIGNATURE OF OFFICER	
31. SIGNATURE OF PATROLMAN		32. SIGNATURE OF TRAFFIC OFFICER		33. SIGNATURE OF INVESTIGATOR	
34. SIGNATURE OF ADJUTANT		35. SIGNATURE OF CLERK		36. SIGNATURE OF RECEPTIONIST	
37. SIGNATURE OF MAIL ROOM		38. SIGNATURE OF TELEPHONE ROOM		39. SIGNATURE OF RECORDS ROOM	
40. SIGNATURE OF SUPPLY ROOM		41. SIGNATURE OF DINING ROOM		42. SIGNATURE OF KITCHEN	
43. SIGNATURE OF LAUNDRY		44. SIGNATURE OF BATHHOUSE		45. SIGNATURE OF GYMNASIUM	
46. SIGNATURE OF RECREATION ROOM		47. SIGNATURE OF CLOTHING ROOM		48. SIGNATURE OF SHOE ROOM	
49. SIGNATURE OF HAT ROOM		50. SIGNATURE OF GLOVE ROOM		51. SIGNATURE OF COAT ROOM	
52. SIGNATURE OF UMBRELLA ROOM		53. SIGNATURE OF TRUNK ROOM		54. SIGNATURE OF BAG ROOM	
55. SIGNATURE OF CASE ROOM		56. SIGNATURE OF SADDLE ROOM		57. SIGNATURE OF BRUSH ROOM	
58. SIGNATURE OF COMB ROOM		59. SIGNATURE OF TOILET ROOM		60. SIGNATURE OF SHOWER ROOM	
61. SIGNATURE OF BATH ROOM		62. SIGNATURE OF DRESSING ROOM		63. SIGNATURE OF BED ROOM	
64. SIGNATURE OF KITCHEN		65. SIGNATURE OF DINING ROOM		66. SIGNATURE OF LIVING ROOM	
67. SIGNATURE OF HALL		68. SIGNATURE OF PORCH		69. SIGNATURE OF PATIO	
70. SIGNATURE OF GARDEN		71. SIGNATURE OF DRIVE		72. SIGNATURE OF GARAGE	
73. SIGNATURE OF PORCH		74. SIGNATURE OF PATIO		75. SIGNATURE OF GARDEN	
76. SIGNATURE OF DRIVE		77. SIGNATURE OF GARAGE		78. SIGNATURE OF PORCH	
79. SIGNATURE OF PATIO		80. SIGNATURE OF GARDEN		81. SIGNATURE OF DRIVE	
82. SIGNATURE OF GARAGE		83. SIGNATURE OF PORCH		84. SIGNATURE OF PATIO	
85. SIGNATURE OF GARDEN		86. SIGNATURE OF DRIVE		87. SIGNATURE OF GARAGE	
88. SIGNATURE OF PORCH		89. SIGNATURE OF PATIO		90. SIGNATURE OF GARDEN	
91. SIGNATURE OF DRIVE		92. SIGNATURE OF GARAGE		93. SIGNATURE OF PORCH	
94. SIGNATURE OF PATIO		95. SIGNATURE OF GARDEN		96. SIGNATURE OF DRIVE	
97. SIGNATURE OF GARAGE		98. SIGNATURE OF PORCH		99. SIGNATURE OF PATIO	
100. SIGNATURE OF GARDEN		101. SIGNATURE OF DRIVE		102. SIGNATURE OF GARAGE	

CERTIFICATE OF DEATH

13703
Reg. Dist. No. 305

13675

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK RURAL				c. LENGTH OF STAY IN 1b 72 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD.R. 1.				d. STREET ADDRESS HAGERSTOWN MD.R.1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EDITH Middle NAOMI Last NEWCOMER				4. DATE OF DEATH Month DECEMBER Day 11 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 7 1874	
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) SKANEATELES NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DAVID Q. STEVENS				14. MOTHER'S MAIDEN NAME HELEN J. STEVENS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT DR. WILLIAM NEWCOMER MT. WILSON MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x General arteriosclerosis with DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO (c) 3 yrs				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 1, 1956 , to Dec 11, 1957 , that I last saw the deceased alive on Dec 8, 1957 , and that death occurred at 6:15 M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 217 W. Washington Street				DATE SIGNED 12/12/57			
ACTUAL SIGNATURE Edward W. Ditto III				M.D. 217 W. Washington Street			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.				Hagerstown, Maryland			
22a. BURIAL, CREMATION, RESURRECTION (Type)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		DEC. 13 1957		BEAVER CREEK CEMETERY		BEAVER CREEK WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Good Funl Home Boonsboro Md.				ADDRESS md.		24a. REC'D BY REGISTRAR DATE Dec. 13-1957	
24b. REGISTRAR'S SIGNATURE John H. Bell							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13676 CERTIFICATE OF DEATH

Reg. Dist. No.

13704
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				e. STREET ADDRESS <u>Leitersburg Pike</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT</u> <u>McCAULEY</u> <u>NEWCOMER</u>				4. DATE OF DEATH Month Day Year <u>Dec 18 1957</u> 19			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feby 12 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin Newcomer</u>				14. MOTHER'S MAIDEN NAME <u>Bettie McCauley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr Edna Hartle Hagerstown Md. R # 3</u>		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphosarcomatosis (Primary in abdomen)</u> <u>200.1</u> DUE TO <u>(Diagnosed from biopsy of cervical gland)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 mos ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 29, 1957</u> to <u>Dec. 18, 1957</u> , that I last saw the deceased alive on <u>Dec. 18, 1957</u> , and that death occurred at <u>4:25P M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>119 North Potomac Street 12-20-57</u>							
ACTUAL SIGNATURE <u>R. A. Bell</u>		M.D. <u>Hagerstown, Maryland.</u>					
PHYSICIAN'S NAME (Type) <u>R. A. Bell, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/21/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				24a. REC'D BY REGISTRAR <u>Dec 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thas. Bowers</u>	

10. STATE DEPARTMENT OF HEALTH—BALTIMORE

BUREAU

DEC 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13677

CERTIFICATE OF DEATH

13705

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 424 North Locust St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY PETERS				4. DATE OF DEATH Month Day Year December 13, 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 10, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Detective		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peters				14. MOTHER'S MAIDEN NAME Emma Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-28-6788		17. INFORMANT Address Mrs. Joanne Cordelli-424 N. Locust St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - General DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 11	Day 13	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Washington
21. I certify that I attended the deceased from Nov. 19, 1957 , to Dec. 13, 1957 , that I last saw the deceased alive on Nov. 19, 1957 , and that death occurred at 12:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 159 W. Washington St., Hagerstown, Md. DATE SIGNED 12/14/57							
ACTUAL SIGNATURE Philip J. Hirshman				M.D. Philip J. Hirshman			
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-16-57	22c. NAME OF CEMETERY OR CREMATORY Most Holy Redemer Ceme. Baltimore, Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew N. Coffran-Hagerstown, Maryland				24a. REC'D BY REGISTRAR Dec. 16, 1957			
				24b. REGISTRAR'S SIGNATURE Charles H. Roewess			

DEC 18 1957

RECEIVED

13678

CERTIFICATE OF DEATH

13706

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 639 Oak Hill Ave.		d. STREET ADDRESS 1 639 Oak Hill Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BEATRICE Middle W. Last POTTER		4. DATE OF DEATH Month December Day 21 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1883
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months 8 Days 14	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) St. John, New Brunswick, Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Welton		14. MOTHER'S MAIDEN NAME ? Steves	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Lucille Taylor		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Atherosclerotic Heart Disease with Cholesterol DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Insufficiency DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myoma of Uterus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/8 , 19 57 , to 12/21 , 19 57 , that I last saw the deceased alive on 12/21 , 19 57 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dalton M. Welty M.D.		ADDRESS (Street, city or town, state) 998 Potomac Ave., Hagerstown, Md	
DATE SIGNED 12/21/57			
PHYSICIAN'S NAME (Type) DALTON M. WELTY		998 POTOMAC AVE. HAGERSTOWN MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/1957	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	22d. LOCATION (City, town, or county) (State) Brooklyn, New York
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Dec. 27, 1957		24b. REGISTRAR'S SIGNATURE Beast H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		RACE _____	
DATE OF BIRTH _____		PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF REGISTRAR _____		SIGNATURE OF JUDGE _____	

BUREAU V. 1

DEC 30 1957

RECEIVED

13679

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 28 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 117 W. Howard St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle Pyles Last Pyles				4. DATE OF DEATH Month 12 Day 19 Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher		10b. KIND OF BUSINESS OR INDUSTRY Brandt Cab. Wks.		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jess Pyles				14. MOTHER'S MAIDEN NAME Florence Hulbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-2200		17. INFORMANT Mrs. Genevieve Pyles Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary occlusion DUE TO (c) Arteriosclerosis gen.						INTERVAL BETWEEN ONSET AND DEATH min min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) asthma auto injury						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/15 , 19 57 , to 12/19 , 19 57 , that I last saw the deceased alive on 12/18/57 , 19 57 , and that death occurred at 12:25 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 E. Antietam St. Hagerstown, Md. DATE SIGNED 12/19/57							
ACTUAL SIGNATURE Louis G. Graff		PHYSICIAN'S NAME (Type) Louis G. GRAFF M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 12-23-57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Dec. 22, 1957		24b. REGISTRAR'S SIGNATURE K. H. Flowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Countersigned DME **WASHINGTON STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Wash. Co. Md.

Dec. 16 '57

CERTIFICATE OF DEATH

13708

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass., b. COUNTY Bristol			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 182 Cottage St.			
3. NAME OF DECEASED (Type or print) First JOHN Middle ELMER Last REESE				4. DATE OF DEATH Month December Day 15 Year 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) New Bedford Gas Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) East Brady-Clarion Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin W. Reese				14. MOTHER'S MAIDEN NAME Penna. Ann Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 026-07-4444		17. INFORMANT Mrs. Ivy Mae Reese		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 12/15, 1957 , to 12/15, 1957 , that I last saw the deceased alive on 12/15, 1957 , and that death occurred at 5:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 West Washington St., DATE SIGNED 12:16:57							
ACTUAL SIGNATURE John H. Hornbaker		M.D. 154 West Washington St.,					
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		Hagerstown, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/57	22c. NAME OF CEMETERY OR CREMATORY St Marys Cemetery	22d. LOCATION (City, town, or county) New Bedford, Mass.	(State) Bristol Co			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland			24a. REC'D BY REGISTRAR Dec. 20, 1957	24b. REGISTRAR'S SIGNATURE Shast/Bowers			

BUREAU V. S.

DEC 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13712

CERTIFICATE OF DEATH

13709
304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HANCOCK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE, MARYLAND</u> 03x2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>8812 OLD HARFORD Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>JANE</u> Last <u>RICHARDS</u>		4. DATE OF DEATH Dec. 14 1957	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31-1876</u> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>KNOXVILLE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. PORTER</u>		14. MOTHER'S MAIDEN NAME <u>Leah WAIRD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>AUSTIN E. RICHARDS - 8812 Old Harford Rd Baltimore Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza and</u> <u>481X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac fibrillation 8 days</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 8</u> , 1957, to <u>Dec 14</u> , 1957, that I last saw the deceased alive on <u>Dec 13</u> , 1957, and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. E. Tobler M.D.</u>		ADDRESS (Street, city or town, state) <u>HANCOCK Md</u> DATE SIGNED <u>12/14/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-17-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc</u>		24a. REC'D BY REGISTRAR <u>12/18/57</u>	
ADDRESS <u>6009 Harford Rd</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Kelly</u>	

DEC 19 1957

RECEIVED

13681 CERTIFICATE OF DEATH

Reg. Dist. No.

13710
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
f. STREET ADDRESS 457 W. Washington				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jesse Middle Scott Last Riser				4. DATE OF DEATH Month 12 Day 16 Year 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1892	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months 12 Days 16 Hours 57		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor				10b. KIND OF BUSINESS OR INDUSTRY W. Md. R.R.		11. BIRTHPLACE (State or foreign country) Cherry Run, W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Benjamin F. Riser				14. MOTHER'S MAIDEN NAME Elizabeth E. Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-10-5391		17. INFORMANT Mrs. Mae Riser Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease 422.1 DUE TO Arterio Sclerotic (General) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1955 (c) 1941							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 16, 1957 to Dec 16, 1957 that I last saw the deceased alive on Dec 16, 1957 , and that death occurred at 7:45 A.M. from the causes and on the date stated above. J. H. Beachley M.D. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Dec 17, 1957							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 12-19-57		22c. NAME OF CEMETERY OR CREMATORY Rest Haven	
22d. LOCATION (City, town, or county) (State) Hagerstown Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Dec 19, 1957		24b. REGISTRAR'S SIGNATURE Chas. E. Coward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 5-1-28		PLACE OF BIRTH MOBILE, ALABAMA	
SEX Male		RACE White		EDUCATION High School	
OCCUPATION None		MARRIAGE Never Married		RELIGION None	
DATE OF DEATH 4-4-68		PLACE OF DEATH Baltimore, Maryland		CAUSE OF DEATH Suicide	
MANNER OF DEATH Suicide		IMMEDIATE CAUSE Shot		MEDICAL OPINION Suicide	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF CORONER J. Edgar Hoover		SIGNATURE OF WITNESSES J. Edgar Hoover	
DATE OF SIGNATURE 4-4-68		DATE OF SIGNATURE 4-4-68		DATE OF SIGNATURE 4-4-68	

BUREAU Y. S.

DEC. 23 1957

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH CODE, TITLE 21, SUBTITLE 10, CHAPTER 1001, SECTION 1001.01, AS AMENDED.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13682 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13711
352

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. COUNTY Sangamon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield 51X-3	
c. LENGTH OF STAY IN 1b 1 1/2 hrs		d. STREET ADDRESS 1616 South 10 1/2 Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Ronald Gilbert Robison		4. DATE OF DEATH Month Day Year Dec. 21 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1936
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Ill		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack Wyatt		14. MOTHER'S MAIDEN NAME Dora Robison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes active		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ronald G. Robison (Wife)		Address Springfield, Ill.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull (closed) 816X DUE TO Haemo-pneumo-thorax hemorrhage & shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car involved in collision with another car	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11:15 Dec. 21 '57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural Hancock Wash (County) Md (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Dec. 21 '57	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/23/57	
22c. NAME OF CEMETERY OR CREMATORY Camp Butler Natl Cem.		22d. LOCATION (City, town, or county) Springfield Sangamon Co (State) Ill	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. REC'D BY REGISTRAR Dec 27, 1957	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 30 1957

BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13683

Item 4 Film G223 12-30-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

30 ✓

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSIAH First Elmer Middle SHEPPARD Last		4. DATE OF DEATH Month December Day 22 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired draftsman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Josiah A. Shepperd		14. MOTHER'S MAIDEN NAME Melissa Armacost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Fred D. Burkholder		Address Hagerstown, Md. 1203 Virginia Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.8 PULMONARY EMBOLISM DUE TO (b) 14m Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) carcinoma of the soft palate & pharynx			INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____ to Dec. 22, 1957 , that I last saw the deceased alive on Dec. 21, 1957 , and that death occurred at 10: a. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE B. B. Kneisley		ADDRESS (Street, city or town, state) 148 W. Wash. St. Hagerstown Md.	
PHYSICIAN'S NAME (Type) B. B. Kneisley		DATE SIGNED 12/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 26, 1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.		ADDRESS 1900 Eutaw Place	
24a. REC'D BY REGISTRAR DEC 26 1957		24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BANGOR, ME		DATE OF DEATH 1957	
NAME OF DECEASED [Faint Name]		SEX [Faint Sex]	
AGE [Faint Age]		RACE [Faint Race]	
PLACE OF BIRTH [Faint Place]		DATE OF BIRTH [Faint Date]	
OCCUPATION [Faint Occupation]		CAUSE OF DEATH [Faint Cause]	
PLACE OF DEATH [Faint Place]		TIME OF DEATH [Faint Time]	
SIGNATURE OF PHYSICIAN [Faint Signature]		SIGNATURE OF REGISTRAR [Faint Signature]	
DATE OF SIGNATURE [Faint Date]		DATE OF SIGNATURE [Faint Date]	

RECEIVED
 DEC 26 1957
 BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **302**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. AETNA RURAL		c. LENGTH OF STAY IN lb 8 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. AETNA RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HAGERSTOWN MD. ROUTE 1			d. STREET ADDRESS HAGERSTOWN MD. ROUTE 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last John Merle Shingleton			4. DATE OF DEATH Month Day Year December 29, 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 2 1905	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD AIRCRAFT GRAFTON W. VA.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME HENRY SHINGLETON			14. MOTHER'S MAIDEN NAME MARY BLACKWOOD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 236 12 6449		17. INFORMANT Address ROBERT L. SHINGLETON HAGERSTOWN MD. R. 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of chest (self inflicted) DUE TO (c) Instant					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted			
20c. TIME OF INJURY Month, Day, Year Hour 8:30 p. m. Dec. 29, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Route 1	(County) Hagerstown, Washington, Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 2 1958	22c. NAME OF CEMETERY OR CREMATORY BLUEMONT CEMETERY	22d. LOCATION (City, town, or county) (State) GRAFTON W. VA.		
23. FUNERAL DIRECTOR'S SIGNATURE Good Funeral Home Boonsboro Md.		ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR JAN 7 1958	24b. REGISTRAR'S SIGNATURE Charles K. Kewer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PNQ. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
NEW YORK

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S OFFICE OF DEATH

BUREAU V. 3

JAN 7 1932

RECEIVED

Handwritten signature

13714

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. AETNA RURAL</u>	c. LENGTH OF STAY IN 1b <u>8 YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X 2 MT. AETNA RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HAGERSTOWN MD. ROUTE 1</u>		d. STREET ADDRESS <u>HAGERSTOWN MD. ROUTE 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Opal</u> Middle <u>Beatrice</u> Last <u>Shingleton</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>19 57</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 23 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAIGLON INC.</u>	
11. BIRTHPLACE (State or foreign country) <u>GRAFTON WEST VIRGINIA U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FLOYD DUCKWORTH</u>		14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214 24 4512</u>	
17. INFORMANT <u>ROBERT L. SHINGLETON</u>		Address <u>HAGERSTOWN MD. R. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>981X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gunshot wound of chest</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in chest by husband.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30</u> <u>Dec. 29, 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		DATE SIGNED <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JANUARY 2 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BLUEMONT CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>GRAFTON W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home Boonsbrow Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 7 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 31

1959 JAN 7

RECEIVED

Handwritten signature

CERTIFICATE OF DEATH

Reg. Dist. No.

302

13684

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS BOONSBORO MD. ROUTE 2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ANNA V. SMITH				4. DATE OF DEATH Month Day Year DECEMBER 18 1957 19			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 9 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTHO J. ITNYRE				14. MOTHER'S MAIDEN NAME MARY SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT HARRY SMITH BOONSBORO MD. ROUTE 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 <i>Concealed atherosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>lobar pneumonia</i> DUE TO (c) <i>2 days</i>						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490.0						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec. 15 , 19 57 , to Dec 18 , 19 57 , that I last saw the deceased alive on Dec. 18 , 19 57 , and that death occurred at 6 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>G. W. Heelan</i>				ADDRESS (Street, city or town, state) Boonsboro			
PHYSICIAN'S NAME (Type) G. W. Heelan				DATE SIGNED 12-20-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 21 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Best Funeral Home Boonsboro Md</i>				ADDRESS Boonsboro Md		24a. REC'D BY REGISTRAR Dec. 24 1957	
				24b. REGISTRAR'S SIGNATURE <i>Shirley H. Bowers</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF CEMETERY		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWEE	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWEE		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

BUREAU V. 3

DEC 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13685 CERTIFICATE OF DEATH

Reg. Dist. No.

13716
302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Greencastle 75X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Mem. Conv. Hospital</u>				d. STREET ADDRESS <u>Rural Route 2-Greencastle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>WILLIAM</u> Middle <u>SMITH</u> Last				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/1872</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Smith</u>				14. MOTHER'S MAIDEN NAME <u>Anna Gross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Sally Smith</u> <u>Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X</u> DUE TO <u>Carcinoma Bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Arterio Sclerosis</u> DUE TO (c) <u>181X</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1-57</u> , 19 <u>57</u> , to <u>Dec 12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 11-57</u> , 19 <u>57</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. E. W. Smith</u>		M.D. <u>H. E. W. Smith</u>		ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u>		DATE SIGNED <u>12-13-57</u>	
PHYSICIAN'S NAME (Type) <u>J. E. W. Smith</u>		M.D. <u>H. E. W. Smith</u>		ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u>		DATE SIGNED <u>12-15-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		22b. DATE THEREOF <u>12/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill U.B.</u>		22d. LOCATION (City, town, or county) (State) <u>Coseytown, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u>				ADDRESS <u>Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>Dec 16 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas. H. Rowers</u>	

BUREAU V. S.

DEC 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13715

CERTIFICATE OF DEATH

Reg. Dist. No.

13717

305

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Rural Boonsboro				c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) Waynesboro			
c. LENGTH OF STAY IN 1b 2 weeks				d. STREET ADDRESS 61 Clayton Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney-Keedy Memorial Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nellie Heefner Snader			4. DATE OF DEATH Month Dec. Day 16 Year 19 57				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Waynesboro, R.D.1 Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME A.S.Heefner			14. MOTHER'S MAIDEN NAME Martha Sprengle				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Warren J. Snader, 61 Clayton Ave. Waynesboro, Pa.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of left hip DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 25 , 19 57 , to Dec 16 , 19 57 , that I last saw the deceased alive on Dec 16 , 19 57 , and that death occurred at 5:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Heefner			ADDRESS (Street, city or town, state) Boonsboro			DATE SIGNED 12/17/57	
PHYSICIAN'S NAME (Type) G. W. Heefner			M.D. Ind				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/1957		22c. NAME OF CEMETERY OR CREMATORY Burns Hill		22d. LOCATION (City, town, or county) (State) Waynesboro Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Gane				ADDRESS Waynesboro, Pa.		24a. REC'D BY REGISTRAR DEC 23 1957	
				24b. REGISTRAR'S SIGNATURE Chas. H. Bost			

CERTIFICATE OF DEATH

Name of Deceased Washington		Sex Male		Age 61	
Place of Birth Washington, D.C.		Race White		Date of Birth Sept. 9, 1882	
Usual Residence 61 Glasgow Ave.		Cause of Death Heart Disease		Date of Death Dec. 28, 1957	
Manner of Death Natural		Occupation None		Signature of Physician [Signature]	
Name of Informant John A. [Name]		Relationship Wife		Signature of Informant [Signature]	
Address of Informant 61 Glasgow Ave.		City Baltimore		State Md.	
County Harford		Date of Report Dec. 29, 1957		Registrar's Signature [Signature]	
Registrar's Name [Name]		Title Registrar		Office Baltimore	

BUREAU V. S.

DEC 28 1957

RECEIVED

13686

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 Yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>				d. STREET ADDRESS <u>211 E. Washington St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>211 E Washington St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD SOUTH</u>				4. DATE OF DEATH Month Day Year <u>December 29 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1 1878</u>	9. AGE (In years last birthday) yrs. <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Funkstown Wash. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William B. South</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6199</u>		17. INFORMANT Address <u>Joe E. South 211 E. Washington St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>5-6 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adeno carcinoma prostate</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>54</u> , to <u>Dec 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>57</u> , and that death occurred at <u>11 20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington Street</u> DATE SIGNED <u>12/30/57</u> ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>217 W. Washington Street</u> PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>Hagerstown, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Chas A. Bowers</u>	

13719

CERTIFICATE OF DEATH

Reg. Dist. No.

302

13687

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Taylor</u> Last <u>Spaid</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1870</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Christa Newcomer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Clarence Tomlinson Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1</u> <u>1955</u> , to <u>Dec. 15, 1957</u> , that I last saw the deceased alive on <u>Dec. 15, 1957</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>214 N. Potomac St. Hagerstown, Md.</u> DATE SIGNED <u>Dec. 16, 57</u>							
ACTUAL SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman Hagerstown, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Deaf Williamsport, Md.</u>				24a. REC'D BY REGISTRAR <u>Dec. 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Paul H. Boevers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13720
302

13688

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 5 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				d. STREET ADDRESS 301 Elizabeth St			
3. NAME OF DECEASED (Type or print) First Middle Last LLOYD DANIEL STONE				4. DATE OF DEATH Month Day Year December 30 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18 1894		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Operator		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State and foreign country) Cumberland Co Mechanicsburg Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Stone				14. MOTHER'S MAIDEN NAME Mary Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-7748		17. INFORMANT Address Mrs Mary L. Schoppert Williamsport Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Tammany Manor Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with coronary insufficiency DUE TO (c) 18 mos.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign prostatic hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 55 , to Dec 30 , 19 57 , that I last saw the deceased alive on Dec 29 , 19 57 , and that death occurred at 6:20 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto				ADDRESS (Street, city or town, state) 217 W. Washington Street		DATE SIGNED 12/30/57	
PHYSICIAN'S NAME (Type) Edward W. Ditto 111, M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/1/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR JAN 2 1958	
				24b. REGISTRAR'S SIGNATURE Chas H Bowers			

JAN 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13689

CERTIFICATE OF DEATH

Reg. Dist. No. 13721

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home				d. STREET ADDRESS 126 W. Franklin St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rufus Middle Edward Last Stottlemeyer				4. DATE OF DEATH Month 12 Day 8 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1869	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Hag. Table Works		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick A. Stottlemeyer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Miss Minnie Stottlemeyer Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Nov , 19 57 , to 8 Dec , 19 57 , that I last saw the deceased alive on 8 Dec , 19 57 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W Wash DATE SIGNED 12/9/57							
ACTUAL SIGNATURE E. Edwin Houchens M.D.				PHYSICIAN'S NAME (Type) E. Edwin Houchens			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-11-57		22c. NAME OF CEMETERY OR CREMATORY Beaver Creek Lutheran		22d. LOCATION (City, town, or county) (State) Beaver Creek Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Dec. 11, 1957		24b. REGISTRAR'S SIGNATURE Shatt. Bowser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968	
AGE		SEX	
35		Male	
RACE		COLOR	
White		White	
BIRTH DATE		BIRTH PLACE	
JAN 12 1933		MEMPHIS, TENN	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 12 1955		MEMPHIS, TENN	
OCCUPATION		CAUSE OF DEATH	
Attorney		Suicide	
PLACE OF DEATH		MANNER OF DEATH	
MEMPHIS, TENN		Suicide	
HOSPITAL		Physician	
St. Francis Hospital		Dr. J. H. Hume	
Funeral Home		Burial Place	
G. W. Burdette & Son		Graceland Cemetery	
Signature of Physician		Signature of Registrar	
J. H. Hume		J. H. Hume	

BUREAU V. S.

DEC 13 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle CARROLL Last TASKER		4. DATE OF DEATH Month DECEMBER Day 9 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1957
9. AGE (In years last birthday) yrs. 8		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY INFANT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACK D. TASKER		14. MOTHER'S MAIDEN NAME THERESA ALEXANDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. JACK D. TASKER		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage & edema DUE TO (c) From birth			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 7, 1957 to Dec. 9, 1957 , that I last saw the deceased alive on Dec. 9, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 12/10/57			
ACTUAL SIGNATURE F. D. Done		M.D. Hagerstown, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REPOSAL (Specify) BURIAL		22b. DATE THEREOF 12/10/57	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR Dec. 11-1957	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Phas H. Bowers	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 5

DEC 13 1957

RECEIVED
BUREAU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13691

CERTIFICATE OF DEATH

Reg. Dist. No.

13723

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield	
c. LENGTH OF STAY IN 1b 1 1/2 Months		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sylvia Middle H. Last Wade		4. DATE OF DEATH Month Dec. Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1886
9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Sabillasville Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddeus Wastler		14. MOTHER'S MAIDEN NAME Alma S. Royer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jean Thompson, Highfield Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Bowel DUE TO (c) Metastasis Lung		INTERVAL BETWEEN ONSET AND DEATH min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 12/7/57 , 19 57 , to 12/4/57 , 19 57 , that I last saw the deceased alive on 12/4/57 , 19 57 , and that death occurred at 10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Louis G. Graff		ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Louis G. GRAFF		DATE SIGNED 12/5/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/57	22c. NAME OF CEMETERY OR CREMATORY Bethel	22d. LOCATION (City, town, or county) (State) Lantz #1, Frederick Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove		24a. REC'D BY REGISTRAR DEC 9 1957	
ADDRESS Waynesboro Pa		24b. REGISTRAR'S SIGNATURE Chas. Brown	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>William A. Wicks</i>		AGE <i>42</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>Dec 11 1915</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>		CITY OF BIRTH <i>St. Louis, Mo.</i>		COUNTRY OF BIRTH <i>U.S.A.</i>	
DATE OF DEATH <i>Dec 11 1957</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		CITY OF DEATH <i>St. Louis, Mo.</i>		COUNTRY OF DEATH <i>U.S.A.</i>		CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		MEDICAL ATTENDANCE <i>Yes</i>	
SIGNATURE OF DECEASED <i>William A. Wicks</i>		SIGNATURE OF NEXT OF KIN <i>John A. Wicks</i>		SIGNATURE OF PHYSICIAN <i>John A. Wicks</i>		SIGNATURE OF CLERK <i>John A. Wicks</i>		SIGNATURE OF REGISTRAR <i>John A. Wicks</i>		SIGNATURE OF JUDGE <i>John A. Wicks</i>		SIGNATURE OF SHERIFF <i>John A. Wicks</i>		SIGNATURE OF CORONER <i>John A. Wicks</i>	
DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>		DATE OF SIGNATURE <i>Dec 11 1957</i>	

RECEIVED
DEC 9 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

302

13692

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 120 Irvin Ave.			
3. NAME OF DECEASED (Type or print) Ida First May Middle Watkins Last				4. DATE OF DEATH December 15 1957 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1875	
9. AGE (In years last birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		11. BIRTHPLACE (State or foreign country) Near Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John S. Watkins				14. MOTHER'S MAIDEN NAME Ann Middlekauff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. ---		17. INFORMANT Miss Emma Watkins Address Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction posterior; diabetes mellitus						INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1949 to Dec. 15, 1957 , that I last saw the deceased alive on Dec. 14, 1957 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. B. Kneisley				ADDRESS (Street, city or town, state) 148 W. Washington Hag. Md. DATE SIGNED 12/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-17-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son ADDRESS Hagerstown Md.				24a. REC'D BY REGISTRAR Dec. 19, 1957 24b. REGISTRAR'S SIGNATURE W. H. Bowers			

CERTIFICATE OF DEATH

Name of Deceased Washington		Sex Male		Age 60 years		Date of Death July 1, 1957	
Place of Birth Washington County, Maryland		Usual Residence Washington		Cause of Death Heart Disease		Manner of Death Natural	
Occupation Teacher		Education High School		Date of Birth July 1, 1900		Date of Death July 1, 1957	
Name of Physician John S. Watkins		Name of Hospital None		Name of Coroner John S. Watkins		Name of Registrar John S. Watkins	
Signature of Physician John S. Watkins		Signature of Coroner John S. Watkins		Signature of Registrar John S. Watkins		Signature of Death Certifier John S. Watkins	
Date of Signature July 1, 1957		Date of Signature July 1, 1957		Date of Signature July 1, 1957		Date of Signature July 1, 1957	
Place of Signature Washington		Place of Signature Washington		Place of Signature Washington		Place of Signature Washington	
Name of Death Certifier John S. Watkins		Name of Death Certifier John S. Watkins		Name of Death Certifier John S. Watkins		Name of Death Certifier John S. Watkins	
Signature of Death Certifier John S. Watkins		Signature of Death Certifier John S. Watkins		Signature of Death Certifier John S. Watkins		Signature of Death Certifier John S. Watkins	
Date of Signature July 1, 1957		Date of Signature July 1, 1957		Date of Signature July 1, 1957		Date of Signature July 1, 1957	
Place of Signature Washington		Place of Signature Washington		Place of Signature Washington		Place of Signature Washington	

BUREAU V. 21

REC-23 1957

RECEIVED

HOPE HILL Cemetery

12-17-57

John F. Minnich & Son, Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13693

CERTIFICATE OF DEATH

Reg. Dist. No.

13725
302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Winfield Middle Scott Last White		4. DATE OF DEATH Month 12 Day 18 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.2.1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 6 Days 16 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Variety Store	
11. BIRTHPLACE (State or foreign country) Morgan County W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur L White		14. MOTHER'S MAIDEN NAME Ellen Dignan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Arthur White		Address W.Main St.Hancock Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 606x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Urinary obstruction DUE TO (c) Coronary occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			
INTERVAL BETWEEN ONSET AND DEATH 72 hours Relieved Acute			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15 , 19 57 , to Dec. 18 , 19 57 , that I last saw the deceased alive on Dec. 18 , 19 57 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Public Square, Hagerstown, Maryland DATE SIGNED 12/20/57			
ACTUAL SIGNATURE J. Walter Layman		M.D. 5 Public Square, Hagerstown, Maryland	
PHYSICIAN'S NAME (Type) J. Walter Layman, M. D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12.21.57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Washington Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Love Hancock Md		ADDRESS Hancock Md	
24a. REC'D BY REGISTRAR Dec 24 1957		24b. REGISTRAR'S SIGNATURE Blair H. Rowers	

